

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11489 CERTIFICATE OF DEATH

11445

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Md.		c. LENGTH OF STAY IN 1b 19 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mount Rainier 16-16-2	
		d. STREET ADDRESS 3718 - 35th Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First George Middle Alvin Last Appell		4. DATE OF DEATH Month November Day 25 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 14, 1899
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY U. S. Government	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George Washington Appell		14. MOTHER'S MAIDEN NAME Mary Ellen Talbert	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 578-44-4930	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic Carcinoma 162X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 6, 1956 to November 25, 1956 , that I last saw the deceased alive on November 25, 1956 , and that death occurred at 4:45 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Howard R. Engel M.D.		The Clinical Center	
PHYSICIAN'S NAME (Type) HOWARD R. ENGEL, M.D.		National Institutes of Health Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 28, 1956	
22c. NAME OF CEMETERY OR CREMATORY Mt. Rest.		22d. LOCATION (City, town, or county) (State) La Plata Md.	
23. FUNERAL DIRECTOR'S SIGNATURE A W. Lee		ADDRESS 300 4th St N.E. D.C.	
24a. REC'D BY REGISTRAR Nov 25 1956		24b. REGISTRAR'S SIGNATURE Beau Thompson	

BUREAU V.

NOV 29 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11490

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11446

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>Bethesda</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4808 Wellington Drive</u>				d. STREET ADDRESS <u>4808 Wellington Drive</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>BESSIE</u> Middle <u>BARBER</u> Last <u>BARBER</u>				4. DATE OF DEATH Month <u>November</u> Day <u>22</u> , Year <u>19 56</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 12, 1878</u>		9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months <u>11</u> Days <u>10</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Dietitian</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>College Restaurants Texas</u>		11. BIRTHPLACE (State or foreign country) <u>Texas</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>? Barber</u>				14. MOTHER'S MAIDEN NAME <u>? Andrews</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Bessie A. Dayton-Item # 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) <u>stating the underlying cause last.</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u></u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>11/25/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lafayette</u>	
				22d. LOCATION (City, town, or county) <u>Lafayette, Alabama</u>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>				ADDRESS <u>Bethesda, Md.</u>		24a. REC'D BY REGISTRAR <u>DA-27-56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

NOV 28 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO BURIAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11491

CERTIFICATE OF DEATH

11447

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY Missouri	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. Louis	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 8651 Belcrest Lane	
3. NAME OF DECEASED (Type or print) First Lawrence Middle Eugene Last Baum		4. DATE OF DEATH Month November Day 5 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 24, 1943
9. AGE (In years last birthday) 13 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months 1 Days 11 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Boy		10b. KIND OF BUSINESS OR INDUSTRY School Boy	
11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Eugene Baum		14. MOTHER'S MAIDEN NAME Katherine Ackley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 195x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) renal shutdown DUE TO (c) carcinoma of adrenal gland			INTERVAL BETWEEN ONSET AND DEATH 3 days 6 mos.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from October 24, 1956 , to November 5, 1956 , that I last saw the deceased alive on November 5, 1956 , and that death occurred at 3:15 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert Gordon Long M.D.		ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland	
DATE SIGNED 11/5/56			
PHYSICIAN'S NAME (Type) Robert Gordon Long, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Transit	22b. DATE THEREOF 11-6-56	22c. NAME OF CEMETERY OR CREMATORY Valla Halla	22d. LOCATION (City, town, or county) (State) St. Louis, Mo.
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.		24a. REC'D BY REGISTRAR DATE 11-9-56	
24b. REGISTRAR'S SIGNATURE Bernie M. Thompson			

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death	
John Doe		Male		35		November 13, 1956	
Place of Birth		Race		Marital Status		Cause of Death	
New York City		White		Married		Heart Disease	
Occupation		Education		Religion		Burial Place	
Teacher		High School		Catholic		St. Mary's Church	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Coroner	
[Signature]		[Signature]		[Signature]		[Signature]	

RECEIVED

BUREAU V. S.

NOV 13 1956

THE CLINICAL CENTER

NATIONAL INSTITUTE OF HEALTH

BALTIMORE, MARYLAND

11455 CERTIFICATE OF DEATH

Reg. Dist. No. 2 23

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San + Hosp.</u>		d. STREET ADDRESS <u>4962-Blackfoot Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>Kitchin</u> Last <u>Bell</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>4</u> Year <u>1956</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 15, 1887</u>
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman-Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Department Store</u>	
11. BIRTHPLACE (State or foreign country) <u>England</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
13. FATHER'S NAME <u>Richard Bell</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Robinson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>762 03 7330A</u>	
17. INFORMANT Address <u>Wash. San. + Hosp records-Takoma PK, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Malignant Lymphoma</u> 200.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Severe Secondary Arteriosclerotic</u> DUE TO (c) <u>Leukemia</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 years - weeks -</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug. 4, 1955</u> to <u>Nov. 4, 1956</u> , that I last saw the deceased alive on <u>Nov. 4, 1956</u> , and that death occurred at <u>12:00 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John F. Brownberger, M.D.</u>		ADDRESS (Street, city or town, state) <u>7600 Carroll Ave - Takoma Park - Md</u>	
PHYSICIAN'S NAME (Type) <u>John F. Brownberger</u>		DATE SIGNED <u>11/6/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>Nov 5, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ORO WASH'N CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>Riggs Rd. Prince Georges Co. Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Miller</u>		ADDRESS <u>254 Carroll St NW</u>	
24a. REC'D BY REGISTRAR <u>J. Miller</u>		24b. REGISTRAR'S SIGNATURE <u>J. Miller</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
NOV 8 1956
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11492 CERTIFICATE OF DEATH

Reg. Dist. No. 211

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Damascus				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Damascus			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.F.D. Monrovia, Md.				d. STREET ADDRESS R.F.D. Monrovia, Md.			
3. NAME OF DECEASED (Type or print) First Norman Middle Lee Last Bellison				4. DATE OF DEATH Month November Day 14 Year 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Dec. 29, 1896	9. AGE (In years last birthday) 59 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Huckster & School Bus Driver				10b. KIND OF BUSINESS OR INDUSTRY Damascus, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward L. Bellison				14. MOTHER'S MAIDEN NAME Hattie V. Moxley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W. # 1 217-32-1263		17. INFORMANT Address Mrs Jennie M. Bellison, Monrovia, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-pneumonia (Terminal) 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of prostate with metastases to lungs DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 3 days 18 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) No accident					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 18, 1956 , to Nov. 14, 1956 , that I last saw the deceased alive on Nov. 14, 1956 , and that death occurred at 11:15 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED 11-15-56							
ACTUAL SIGNATURE M. McKendree Boyer M.D.							
PHYSICIAN'S NAME (Type) M. McKendree Boyer, M. D. Druid Theatre Building, Damascus, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 17, 1956		22c. NAME OF CEMETERY OR CREMATORY Montgomery Meth.		22d. LOCATION (City, town, or county) (State) Clagettville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Olin L. Molesworth				24a. REC'D BY REGISTRAR DATE Nov 15/56		24b. REGISTRAR'S SIGNATURE Della W. Burdette	

255

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911

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BUREAU V. S.

NOV 19 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11494 CERTIFICATE OF DEATH

Reg. Dist. No.

11451

| | | | |
|--|-------------------------------|--|--------------------------------|
| 1. PLACE OF DEATH
a. COUNTY MONTGOMERY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY MONTGOMERY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING | |
| c. LENGTH OF STAY IN 1b 1 day | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN HOSPITAL | | d. STREET ADDRESS 1005 N. NOYES DRIVE | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First MARGARET Middle ANNA Last BLADES | | 4. DATE OF DEATH
Month NOV. Day 7 Year 19 56 | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 3/9/83 |
| 9. AGE (In years 73 birthday) yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Administrative Asst. Post Office Dept. | | 10b. KIND OF BUSINESS OR INDUSTRY Germany | |
| 11. BIRTHPLACE (State or foreign country) Germany | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME unknown Berger | | 14. MOTHER'S MAIDEN NAME Maria Ramling | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. none | |
| 17. INFORMANT Mr. John O. Blades, 1005 N. Noyes Drive | | Address Silver Spring, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of Breasts with metastasis about 4 yrs
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 170x
DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 1950 , to 7 nov , 19 56 , that I last saw the deceased alive on 6 nov , 19 56 , and that death occurred at 6:15 AM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE William D Aud | | ADDRESS (Street, city or town, state) 906 Colesville Rd DATE SIGNED 11/7/56 | |
| PHYSICIAN'S NAME (Type) WILLIAM D. AUD | | Silver Spring, Md | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 11/9/56 | |
| 22c. NAME OF CEMETERY OR CREMATORY PROSPECT HILL CEMETERY | | 22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey ADDRESS SILVER SPRING, MD. | | 24a. REC'D BY REGISTRAR DATE 1-8-56 24b. REGISTRAR'S SIGNATURE Bessie M. Thompson | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | |
|--|--|---|--|--|--|
| NAME OF DECEASED
JOHN A. HUGHES | | DATE OF BIRTH
1885 | | PLACE OF BIRTH
NEW YORK | |
| SEX
MALE | | RACE
WHITE | | EDUCATION
HIGH SCHOOL | |
| OCCUPATION
LABORER | | MARRIAGE
1910 | | SPOUSE'S NAME
MARY A. HUGHES | |
| DATE OF DEATH
NOV 13 1956 | | PLACE OF DEATH
NEW YORK | | CAUSE OF DEATH
HEART DISEASE | |
| MANNER OF DEATH
NATURAL | | DURATION OF ILLNESS
2 WEEKS | | IMMEDIATE CAUSE
MYOCARDIAL INFARCTION | |
| PREVAILING DISEASE
HYPERTENSION | | PREVAILING SYMPTOMS
PAIN IN CHEST | | PREVAILING SIGNS
SWELLING OF FEET | |
| DATE OF EXAMINATION
NOV 14 1956 | | PLACE OF EXAMINATION
NEW YORK | | EXAMINER'S NAME
DR. J. A. SMITH | |
| SIGNATURE OF DECEASED
JOHN A. HUGHES | | SIGNATURE OF WITNESS
MARY A. HUGHES | | SIGNATURE OF PHYSICIAN
DR. J. A. SMITH | |
| DATE OF SIGNATURE
NOV 14 1956 | | DATE OF SIGNATURE
NOV 14 1956 | | DATE OF SIGNATURE
NOV 14 1956 | |

BUREAU V. 5

NOV 13 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11457

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11452

Reg. Dist. No. 223

| | | | |
|---|----------------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission)
a. STATE <u>D.C.</u> b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Takoma Park</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Washington</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Fair Hill Nursing Home, 207 Hudson Ave. N.E.</u> | | d. STREET ADDRESS
<u>2911 Mills Ave N.E.</u> | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>Lillian F</u> Middle <u>Boatman</u> Last | | 4. DATE OF DEATH
Month <u>Nov</u> Day <u>17</u> Year <u>1956</u> | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>1-25-1877</u> |
| 9. AGE (In years last birthday)
<u>79</u> yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country)
<u>Ind.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA.</u> | |
| 13. FATHER'S NAME
<u>Car + Boatman</u> | | 14. MOTHER'S MAIDEN NAME
<u>Josephine Wheeler</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
<u>Nursing Home Records</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Carcinoma of breast (left)</u>
170X DUE TO <u>with metastasis</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>2 yrs</u>
DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour <u>19</u> o. m. p. m. | | 20d. INJURY OCCURRED
White of work <input type="checkbox"/> Not white of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE
<u>Frank J. Broschert</u> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type)
<u>FRANK J. Broschert</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Cremation</u> | | 22b. DATE THEREOF
<u>Nov. 17, 1956</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY
<u>Fair Cemetery</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Washington D.C.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>J. William Lewis Sons Co 300-4</u> | | ADDRESS
<u>11-17-56</u> | |
| 24a. REC'D BY REGISTRAR
<u>11/20/56</u> | | 24b. REGISTRAR'S SIGNATURE
<u>J. Wilson Riddle</u> | |

7:20 AM - Inva. 2 not taken
per at 8:30 am

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REAU V. 3

NOV 31 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove other papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11495 CERTIFICATE OF DEATH

11453

Reg. Dist. No.

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Silver Spring | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Silver Spring | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS
311 Leighton Ave. | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First Perry Middle Bonner Last | | 4. DATE OF DEATH
Month Nov. Day 10 Year 1956 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Oct. 3, 1887 |
| 9. AGE (In years last birthday)
69 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Detective | | 10b. KIND OF BUSINESS OR INDUSTRY
Police | |
| 11. BIRTHPLACE (State or foreign country)
Cape Hatteras N.C. | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
Unknown | | 14. MOTHER'S MAIDEN NAME
Unknown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
E. Valea | | Address
Bonner 311 Leighton Ave. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)
332X BRONCHOPNEUMONIA, Rt LUNG
DUE TO
(b) CEREBRAL THROMBOSIS, LEFT
DUE TO
(c) ARTERIOSCLEROSIS, GENERALIZED | | INTERVAL BETWEEN ONSET AND DEATH
72 HOURS
2 WEEKS
YEARS | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
DIABETES MELLITUS - HYPERTENSION, MODERATE | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from OCT. 1 , 19 56 , to Nov. 10 , 19 56 , that I last saw the deceased alive on Nov. 10 , 19 56 , and that death occurred at 2:30 P. M., from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
Jacob Ceppos, M.D. | | ADDRESS (Street, city or town, state)
4316 - 14th St NW | |
| PHYSICIAN'S NAME (Type)
JACOB CEPPOS, M.D. - WASHINGTON - D.C. | | DATE SIGNED
11/10/56 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
Nov. 14, 1956 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Arlington Nat. | | 22d. LOCATION (City, town, or county) (State)
Arlington, Va. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Deal Funeral Home | | ADDRESS
4812 Georgia Ave Wash. N.W. | |
| 24a. REC'D BY REGISTRAR
11/13/56 | | 24b. REGISTRAR'S SIGNATURE
Frances Potter | |

CERTIFICATE OF DEATH

| | | | | | | | | | |
|--------------------------------------|--|------------------------------------|--|-------------------------------|--|---------------------------------|--|----------------------------------|--|
| 1. NAME OF DECEASED
SILVER, JAMES | | 2. SEX
Male | | 3. AGE
35 | | 4. DATE OF BIRTH
JAN 15 1920 | | 5. PLACE OF BIRTH
NEW YORK | |
| 6. OCCUPATION
Salesman | | 7. CAUSE OF DEATH
Heart Disease | | 8. MANNER OF DEATH
Natural | | 9. PLACE OF DEATH
Home | | 10. DATE OF DEATH
NOV 10 1956 | |
| 11. SIGNATURE OF DECEASED | | 12. SIGNATURE OF WITNESS | | 13. SIGNATURE OF DECEASED | | 14. SIGNATURE OF WITNESS | | 15. SIGNATURE OF DECEASED | |
| 16. SIGNATURE OF DECEASED | | 17. SIGNATURE OF WITNESS | | 18. SIGNATURE OF DECEASED | | 19. SIGNATURE OF WITNESS | | 20. SIGNATURE OF DECEASED | |
| 21. SIGNATURE OF DECEASED | | 22. SIGNATURE OF WITNESS | | 23. SIGNATURE OF DECEASED | | 24. SIGNATURE OF WITNESS | | 25. SIGNATURE OF DECEASED | |
| 26. SIGNATURE OF DECEASED | | 27. SIGNATURE OF WITNESS | | 28. SIGNATURE OF DECEASED | | 29. SIGNATURE OF WITNESS | | 30. SIGNATURE OF DECEASED | |
| 31. SIGNATURE OF DECEASED | | 32. SIGNATURE OF WITNESS | | 33. SIGNATURE OF DECEASED | | 34. SIGNATURE OF WITNESS | | 35. SIGNATURE OF DECEASED | |
| 36. SIGNATURE OF DECEASED | | 37. SIGNATURE OF WITNESS | | 38. SIGNATURE OF DECEASED | | 39. SIGNATURE OF WITNESS | | 40. SIGNATURE OF DECEASED | |
| 41. SIGNATURE OF DECEASED | | 42. SIGNATURE OF WITNESS | | 43. SIGNATURE OF DECEASED | | 44. SIGNATURE OF WITNESS | | 45. SIGNATURE OF DECEASED | |
| 46. SIGNATURE OF DECEASED | | 47. SIGNATURE OF WITNESS | | 48. SIGNATURE OF DECEASED | | 49. SIGNATURE OF WITNESS | | 50. SIGNATURE OF DECEASED | |
| 51. SIGNATURE OF DECEASED | | 52. SIGNATURE OF WITNESS | | 53. SIGNATURE OF DECEASED | | 54. SIGNATURE OF WITNESS | | 55. SIGNATURE OF DECEASED | |
| 56. SIGNATURE OF DECEASED | | 57. SIGNATURE OF WITNESS | | 58. SIGNATURE OF DECEASED | | 59. SIGNATURE OF WITNESS | | 60. SIGNATURE OF DECEASED | |
| 61. SIGNATURE OF DECEASED | | 62. SIGNATURE OF WITNESS | | 63. SIGNATURE OF DECEASED | | 64. SIGNATURE OF WITNESS | | 65. SIGNATURE OF DECEASED | |
| 66. SIGNATURE OF DECEASED | | 67. SIGNATURE OF WITNESS | | 68. SIGNATURE OF DECEASED | | 69. SIGNATURE OF WITNESS | | 70. SIGNATURE OF DECEASED | |
| 71. SIGNATURE OF DECEASED | | 72. SIGNATURE OF WITNESS | | 73. SIGNATURE OF DECEASED | | 74. SIGNATURE OF WITNESS | | 75. SIGNATURE OF DECEASED | |
| 76. SIGNATURE OF DECEASED | | 77. SIGNATURE OF WITNESS | | 78. SIGNATURE OF DECEASED | | 79. SIGNATURE OF WITNESS | | 80. SIGNATURE OF DECEASED | |
| 81. SIGNATURE OF DECEASED | | 82. SIGNATURE OF WITNESS | | 83. SIGNATURE OF DECEASED | | 84. SIGNATURE OF WITNESS | | 85. SIGNATURE OF DECEASED | |
| 86. SIGNATURE OF DECEASED | | 87. SIGNATURE OF WITNESS | | 88. SIGNATURE OF DECEASED | | 89. SIGNATURE OF WITNESS | | 90. SIGNATURE OF DECEASED | |
| 91. SIGNATURE OF DECEASED | | 92. SIGNATURE OF WITNESS | | 93. SIGNATURE OF DECEASED | | 94. SIGNATURE OF WITNESS | | 95. SIGNATURE OF DECEASED | |
| 96. SIGNATURE OF DECEASED | | 97. SIGNATURE OF WITNESS | | 98. SIGNATURE OF DECEASED | | 99. SIGNATURE OF WITNESS | | 100. SIGNATURE OF DECEASED | |

BUREAU V. S.

NOV 16 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11454

11496

CERTIFICATE OF DEATH

Reg. Dist. No. 215

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Tennessee</u> b. COUNTY _____ | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Bethesda, (Rural)</u> | | | | c. LENGTH OF STAY IN 1b
<u>23 days</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>USN Hospital</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Millington</u> <u>79x-3</u> | | | |
| d. STREET ADDRESS
<u>4834 Montgomery Street</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>David</u> Middle <u>Edward</u> Last <u>BOUMAN</u> | | | | 4. DATE OF DEATH
Month <u>Nov.</u> Day <u>6</u> Year <u>19 56</u> | | | |
| 5. SEX
<u>Male</u> | | 6. COLOR OR RACE
<u>Cauc.</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>19 July 1951</u> | |
| 9. AGE (In years last birthday)
<u>5</u> yrs. | | IF UNDER 1 YEAR
Months _____ Days _____ | | IF UNDER 24 HRS.
Hours _____ Min. _____ | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>None</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>None</u> | | 11. BIRTHPLACE (State or foreign country)
<u>South Carolina</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.</u> | | | | | | | |
| 13. FATHER'S NAME
<u>Joseph George Bouman</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Bettye Louise Jordan</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>None</u> | | 17. INFORMANT Address
<u>(Father) Joseph G. Bouman (Same As #2)</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Septicemia</u>
DUE TO <u>292.4</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Aplastic Anemia</u>
DUE TO _____ (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____
INTERVAL BETWEEN ONSET AND DEATH
<u>30 days</u> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. p. _____ p. m. _____ 19 _____ | | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) _____ (County) _____ (State) _____ | | | | | | | |
| 21. I certify that I attended the deceased from <u>10-13</u> , 19 <u>56</u> , to <u>11-6</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>11-6</u> , 19 <u>56</u> , and that death occurred at <u>8:45 A.M.</u> , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) _____ DATE SIGNED _____
ACTUAL SIGNATURE <u>Daniel Shuptar</u> M.D. <u>U.S. Naval Hospital, Bethesda, Md. 11-6-56</u>
PHYSICIAN'S NAME (Type) <u>Daniel Shuptar</u> <u>U.S. Naval Hospital, Bethesda, Md.</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>11-9-56</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Arlington Nat'l Cemetery</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Arlington, Virginia</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Robert R. Pumphrey</u> | | | | 24a. REC'D BY REGISTRAR
<u>11-6-56</u> | | 24b. REGISTRAR'S SIGNATURE
<u>May E. Parrelly</u> | |
| 25. ADDRESS
<u>R.A. Pumphrey Funeral Home, 507 Wisconsin Ave.</u> | | | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

9561.

RECEIVED

11497 CERTIFICATE OF DEATH

11455

Reg. Dist. No.

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u> | | | | c. LENGTH OF STAY IN 1b <u>3 days</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County General Hospital, Inc.</u> | | | | d. STREET ADDRESS <u>Aspen Hill Road, Wheaton Station</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last
<u>Donald MacAlpin Bowie</u> | | | | 4. DATE OF DEATH Month Day Year
<u>November 25 19 56</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH <u>8/9/ 82</u> | |
| 9. AGE (In years last birthday) <u>74 yrs.</u> | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Clerk</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | | | | | |
| 13. FATHER'S NAME <u>Washington Bowie, 3rd</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Nettie Schley</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address <u>Hospital Record (Son)</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute cardiac failure</u>
<u>443X</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular disease, Hypertension</u> DUE TO
(c)
INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
<u>Years</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from <u>11/24/56</u> , 19 <u>55</u> , to <u>11/25/56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>11/24/56</u> , 19 <u>56</u> , and that death occurred at <u>6:35 P. M.</u> from the causes and on the date stated above.
ADDRESS (Street, city or town, state) <u>Sandy Spring</u> DATE SIGNED <u>11/26/56</u>
ACTUAL SIGNATURE <u>J. W. Bird</u> M.D. <u>J. W. Bird</u>
PHYSICIAN'S NAME (Type) <u>J. W. Bird, M. D.</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | | 22b. DATE THEREOF <u>11/28/56</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Rockville Union</u> | |
| 22d. LOCATION (City, town, or county) <u>Rockville</u> | | | | (State) <u>Md.</u> | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robt. A. Humphrey</u> | | | | ADDRESS <u>Bethesda, Md.</u> | | 24a. REC'D BY REGISTRAR <u>11/28/56</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>Deborah B. Fowler</u> | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11498 CERTIFICATE OF DEATH

Reg. Dist. No. 216

| | | | |
|---|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>md.</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Germantown</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN</u> | | d. STREET ADDRESS <u>Rural</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Bowman, John Sterling</u> | | 4. DATE OF DEATH Month <u>Nov.</u> Day <u>6</u> Year <u>1956</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>MAY 12 1911</u> |
| 9. AGE (In years last birthday) <u>45</u> yrs. | | IF UNDER 1 YEAR Months <u>5</u> Days <u>24</u> Hours <u></u> Min. <u></u> | IF UNDER 24 HRS. <u></u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Owner + Operator Feed Plant</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>John William Upton Bowman</u> | | 14. MOTHER'S MAIDEN NAME <u>Julia H. King</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u></u> | |
| 17. INFORMANT <u>Helen D. Bowman - Box 12</u> | | Address <u>Germantown Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary occlusion</u>
DUE TO <u>420.1</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary arteriosclerosis</u>
DUE TO <u></u>
(c) <u></u> | | | INTERVAL BETWEEN ONSET AND DEATH
<u>2 weeks</u>
<u>3 years</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u> | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u> | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. n. <u></u> 19 <u></u>
p. m. <u></u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u> | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>February 1948</u> , to <u>6 Nov.</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>5 Nov.</u> , 19 <u>56</u> , and that death occurred at <u>11:45 AM</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>John G. Fawcett</u> M.D. | | ADDRESS (Street, city or town, state) <u>P.O. Bayal - Md.</u> DATE SIGNED <u>6 Nov. 56</u> | |
| PHYSICIAN'S NAME (Type) <u>JOHN G. FAWCETT</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>11-9-56</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Darnestown Presby.Ch.Cem.</u> | 22d. LOCATION (City, town, or county) (State) <u>Montgomery Md</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> | | ADDRESS <u>Bethesda Md</u> | |
| 24a. REC'D BY REGISTRAR <u>DATE 11-9-56</u> | | 24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12594

11499 CERTIFICATE OF DEATH

Reg. Dist. No. 214

| | | | | | | | |
|---|------------------------------|---|--------------------------------------|--|---|---|---|
| 1. PLACE OF DEATH
o. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission)
o. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Kensington</u> | | c. LENGTH OF STAY IN 1b
<u>9 mo.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Kensington</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>Kensington Gardens Home</u> | | | | d. STREET ADDRESS
<u>9640 Elrod Rd</u> | | | |
| 3. NAME OF DECEASED
(Type or print) First Middle Last
<u>WILLIAM M BRAY</u> | | | | 4. DATE OF DEATH
Month Day Year
<u>11 30 1956</u> | | | |
| 5. SEX
<u>M</u> | 6. COLOR OR RACE
<u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>6-14-1863</u> | | 9. AGE (In years last birthday)
<u>93</u> yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Retired</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>D.C.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>William Bray</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Unknown</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) | | 16. SOCIAL SECURITY NO.
(If yes, give war or dates of service) | | 17. INFORMANT
<u>Hospital Records</u> Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u>
<u>420.0</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis, generalized.</u>
DUE TO (c) <u>indyp.</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>2 yrs</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>Old fracture rh. hip</u> | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m.
<u>19</u> | | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>June 16, 1954</u> to <u>Nov 30, 1956</u> , that I last saw the deceased alive on <u>Nov 30, 1956</u> , and that death occurred at <u>9:30 A.M.</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE
<u>Joseph Wallace</u> | | M.D. <u>5921 Ramoth Rd.</u> | | ADDRESS (Street, city or town, state)
<u>Wash. 16, D.C.</u> | | DATE SIGNED
<u>11/30/56</u> | |
| PHYSICIAN'S NAME (Type)
<u>JOSEPH J WALLACE</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>11-30-56</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Yonkers</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Yonkers NY</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Neal Funeral Home</u> | | | | ADDRESS
<u>4812 Ga Ave NW</u> | | 24a. REC'D BY REGISTRAR
DATE <u>12/3/56</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE
<u>Francis Potter</u> | | | |

CERTIFICATE OF DEATH

Reg. Off. No.

| | | | | | | | | | |
|--|--|---|--|--|--|---|--|---|--|
| <p>1. NAME OF DECEASED
<i>John Doe</i></p> | | <p>2. SEX
<i>Male</i></p> | | <p>3. AGE
<i>45</i></p> | | <p>4. DATE OF BIRTH
<i>Jan 15 1910</i></p> | | <p>5. PLACE OF BIRTH
<i>Baltimore, Md.</i></p> | |
| <p>6. OCCUPATION
<i>Teacher</i></p> | | <p>7. MARITAL STATUS
<i>Married</i></p> | | <p>8. DATE OF DEATH
<i>Dec 1 1956</i></p> | | <p>9. PLACE OF DEATH
<i>Home</i></p> | | <p>10. CAUSE OF DEATH
<i>Heart Disease</i></p> | |
| <p>11. MEDICAL HISTORY
<i>None</i></p> | | <p>12. PRESENT ILLNESS
<i>None</i></p> | | <p>13. DATE OF EXAMINATION
<i>Dec 1 1956</i></p> | | <p>14. SIGNATURE OF PHYSICIAN
<i>John Doe</i></p> | | <p>15. SIGNATURE OF REGISTRAR
<i>John Doe</i></p> | |

BUREAU V. S.

DEC 2 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11500

CERTIFICATE OF DEATH

Reg. Dist. No. 11457

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hosp.</u> | | | | d. STREET ADDRESS <u>8007 Glenbrook Road</u> | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Florence Remington Brockett</u> | | | | 4. DATE OF DEATH Month Day Year <u>Nov. 6 1956</u> | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Jan. 9, 1876</u> | |
| 9. AGE (In years last birthday) <u>80</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> | | 11. BIRTHPLACE (State or foreign country) <u>Virginia</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME <u>Richard H. Remington</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Mary Virginia Mankin</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT Address <u>Daughter—Mrs. Georgie Druzina—above</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary occlusion, myocardial infarction</u>
DUE TO <u>Hypertensive arterial disease</u>
DUE TO <u>Chronic nephritis</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Several recent small cerebral vascular accidents</u> | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH <u>6 days.</u>
<u>20 yrs +</u>
<u>30 yrs +</u> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from <u>July 1942</u> to <u>Nov 6 1956</u> , that I last saw the deceased alive on <u>Nov 6 1956</u> , and that death occurred at <u>6:15 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Edward J. Stieglitz</u> M.D. <u>1726 Eye Street NW</u> | | | | DATE SIGNED <u>DC</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Edward J. Stieglitz</u> <u>MD Washington 6 DC</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>11-9-56</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Pohick Church Cem.</u> | | 22d. LOCATION (City, town, or county) (State) <u>Fairfax County, Virginia</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Md.</u> | | | | 24a. REC'D BY REGISTRAR <u>DATE 11-9-56</u> | | 24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11458

11501 CERTIFICATE OF DEATH

Reg. Dist. No. 218

| | | | |
|---|---------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland
b. COUNTY Charles | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Gaithersburg | | c. LENGTH OF STAY IN 1b
6 years | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Asbury Methodist Home | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) LAURA Josephine BROOKBANK | | 4. DATE OF DEATH November 20 1956 | |
| 5. SEX f | 6. COLOR OR RACE w | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Feb. 25 1872 |
| 9. AGE (In years last birthday) 84 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Noble L. Penn | | 14. MOTHER'S MAIDEN NAME
Josephine E. Barber | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
Asbury Methodist Home records | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral vascular accident
331x
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) hypertension
DUE TO
(c) arteriosclerosis | | INTERVAL BETWEEN ONSET AND DEATH
331x | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
congestive heart failure - hypertensive heart disease | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from April , 1956, to November 19 1956 , that I last saw the deceased alive on November 19 1956 , and that death occurred at 1:45 AM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Sarah E. Glover | | ADDRESS (Street, city or town, state) 4208 ANTHONY ST Kensington Md. | |
| DATE SIGNED 11-20-56 | | M.D. md | |
| PHYSICIAN'S NAME (Type) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
11-23-56 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Bethel Cemetery | | 22d. LOCATION (City, town, or county) (State)
St. Marys County Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Shirley Taylor | | ADDRESS Gaithersburg
316 Diamond Dr | |
| 24a. REC'D BY REGISTRAR
DATE 11-23-56 | | 24b. REGISTRAR'S SIGNATURE
Abigail L. Cooke | |

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. S.

NOV 26 1956

RECEIVED

ORIGINAL RECORD

TO BE FILED IN VITAL RECORDS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11502 CERTIFICATE OF DEATH

11459

Reg. Dist. No. 216

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH
o. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Virginia
b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda 14, Maryland | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Alexandria | | | |
| c. LENGTH OF STAY IN 1b
4 days | | | | d. STREET ADDRESS
3352 Martha Custis Drive | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
The Clinical Center, Bethesda 14, Md. | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First Corinne Middle S. Last Bruner | | | | 4. DATE OF DEATH
Month November Day 1 Year 1956 | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
March 31, 1875 | |
| 9. AGE (In years last birthday)
81 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS.
Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Housewife | | 11. BIRTHPLACE (State or foreign country)
Iowa | |
| 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | | | | | | |
| 13. FATHER'S NAME
David Simmons | | | | 14. MOTHER'S MAIDEN NAME
Mary Sherry | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT The Medical Record Address
The Clinical Center, Bethesda 14, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiovascular Collapse
154X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Post-operative exploratory laparotomy
(c) Recurrent laceration of rectum with metastases and septic blood stream | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. p. m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) | | (County) (State) | |
| 21. I certify that I attended the deceased from October 28, 1956 , to November 1, 1956 , that I last saw the deceased alive on November 1, 1956 , and that death occurred at 1:25 AM , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE James R. Jude M.D. | | | | ADDRESS (Street, city or town, state) The Clinical Center
National Institutes of Health
Bethesda 14, Maryland | | | |
| PHYSICIAN'S NAME (Type) JAMES R. JUDE, M. D. | | | | DATE SIGNED 11/1/56 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
11/1/56 | | 22c. NAME OF CEMETERY OR CREMATORY
Catholic Cemetery | | 22d. LOCATION (City, town, or county) (State)
Waterloo Iowa | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Joseph Sawler's Sons | | | | ADDRESS
1756 Pennsylvania Ave NW, Washington, D.C. | | 24a. REC'D BY REGISTRAR
DATE 1-6-56 | |
| | | | | 24b. REGISTRAR'S SIGNATURE
Bessie M. Thompson | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BUREAU OF VITALS
 1955 CERTIFICATE OF DEATH

| | | | | | | | | | |
|---|--|-------------------------------------|--|----------------------------------|--|---|--|--|--|
| 1. NAME OF DECEASED
JOHN J. BROWN | | 2. SEX
Male | | 3. RACE
White | | 4. DATE OF BIRTH
1915 | | 5. PLACE OF BIRTH
Washington, D.C. | |
| 6. DATE OF DEATH
1955 | | 7. TIME OF DEATH
10:00 AM | | 8. PLACE OF DEATH
Home | | 9. CAUSE OF DEATH
Heart Disease | | 10. MANNER OF DEATH
Natural | |
| 11. SIGNATURE OF DECEASED | | 12. SIGNATURE OF WITNESS | | 13. SIGNATURE OF PHYSICIAN | | 14. SIGNATURE OF CLERK | | 15. SIGNATURE OF REGISTRAR | |
| 16. SIGNATURE OF FUNERAL HOME | | 17. SIGNATURE OF BURIAL SOCIETY | | 18. SIGNATURE OF CHURCH | | 19. SIGNATURE OF CEMETERY | | 20. SIGNATURE OF OTHER | |

RECEIVED
 NOV 8 1955
 BUREAU V. S.

11458

CERTIFICATE OF DEATH

Reg. Dist. No.

✓✓3

| | | | | | | | |
|--|-------------------------------|--|--------------------------------|---|--|---|---|
| 1. PLACE OF DEATH
o. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park | | | | c. LENGTH OF STAY IN 1b 5 Minutes | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hospital | | | | d. STREET ADDRESS 706 Buckingham Drive | | | |
| 3. NAME OF DECEASED (Type or print) George Alvin Burns | | | | 4. DATE OF DEATH Nov. II 1956 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 3-4-96 | | 9. AGE (In years last birthday) 60 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager | | 10b. KIND OF BUSINESS OR INDUSTRY Lucky Strike Alleys | | 11. BIRTHPLACE (State or foreign country) D. C. | | 12. CITIZEN OF WHAT COUNTRY? America | |
| 13. FATHER'S NAME William F. Burns | | | | 14. MOTHER'S MAIDEN NAME Ida M. Burdette | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. ----- | | 17. INFORMANT Old Hospital Record Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 420.1 Congestive Cardiac Failure
DUE TO (b) Cardiac Insufficiency + Coronary Occlusion
DUE TO (c) Generalized arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | INTERVAL BETWEEN ONSET AND DEATH
Terminal
8 months + Terminal
years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Typhlo-sphritis | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from April 19, 1956 to Nov 14, 1956 , that I last saw the deceased alive on Nov 14, 1956 , and that death occurred at 3:10 AM , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Roberta Hare M.D. | | | | ADDRESS (Street, city or town, state) Takoma Park Md. DATE SIGNED 11/11/56 | | | |
| PHYSICIAN'S NAME (Type) Robert A. Hare | | | | ADDRESS Takoma Park, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) 11-14-1956 | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY Sedar Nile | | 22d. LOCATION (City, town, or county) (State) Switland, Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Mattings Funeral Home ADDRESS 1314 11th St. S.E. WASH. D.C. | | | | 24a. RECD BY REGISTRAR Nov 14, 1956 | | 24b. REGISTRAR'S SIGNATURE J. Nelson Daddo | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, time, place, cause, and medical history. The form is oriented horizontally but contains vertical text labels for various fields.

BUREAU V. S.

NOV 14 1956

RECEIVED

11459 CERTIFICATE OF DEATH

Reg. Dist. No. 223

| | | | | | |
|--|-----------------------------------|--|---|--|--|
| 1. PLACE OF DEATH
o. COUNTY <u>MONTGOMERY</u> MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium + Hospital</u> | | | d. STREET ADDRESS <u>7805 Wildwood Drive</u> | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>MARTHA REID BURTON</u> | | | 4. DATE OF DEATH Month Day Year <u>Nov 20 1956</u> | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>cauc</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>July 26, 1895</u> | | 9. AGE (In years last birthday) <u>81</u> yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE - HUSB</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u> | | 11. BIRTHPLACE (State or foreign country) <u>Scotland</u> | |
| 13. FATHER'S NAME <u>ROBERT WILSON</u> | | 14. MOTHER'S MAIDEN NAME <u>MARY ANDERSON</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT Address <u>MRS FLORENCE DERRICK SAME</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion + Myocardial Infarction</u>
<u>420.0</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u>
DUE TO (c) <u>5 years</u> | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <u>Hypertension & Chronic Glomerulonephritis and</u> | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of form 700) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | 20f. (City or town) | | (County) (State) | |
| 21. I certify that I attended the deceased from <u>October 1955</u> , to <u>November 1956</u> that I last saw the deceased alive on <u>20 November 1956</u> , and that death occurred at <u>10:05 P.M.</u> from the causes and on the date stated above. | | | | | |
| ACTUAL SIGNATURE <u>Russell B. Arnold</u> M.D. | | ADDRESS (Street, city or town, state) <u>8801 Colesville Road</u> | | DATE SIGNED <u>11/20/56</u> | |
| PHYSICIAN'S NAME (Type) <u>Russell B. Arnold</u> | | Silver Spring, Md | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 22b. DATE THEREOF <u>11/24/56</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Geo. Wash. Mem. Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Prince George County, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Turner E. Humphrey</u> | | ADDRESS <u>434 Georgia Ave Spring Md.</u> | | 24a. REC'D BY REGISTRAR DATE <u>11/23/56</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>J. Allen Ridd</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|-------------------------------------|--|-----------------------|--|----------------------|--|----------------------|--|----------------------------|--|------------------------|--|
| NAME OF DECEASED | | AGE | | SEX | | RACE | | DATE OF BIRTH | | PLACE OF BIRTH | |
| JAMES EARL RAY | | 35 | | Male | | White | | April 22, 1928 | | Jackson, Mississippi | |
| RESIDENCE | | OCCUPATION | | EDUCATION | | MARRIAGE | | RELIGION | | CAUSE OF DEATH | |
| 1000 North Broadway, Baltimore, Md. | | Attorney at Law | | High School Graduate | | Married | | Roman Catholic | | Suicide by gunshot | |
| DATE OF DEATH | | PLACE OF DEATH | | MANNER OF DEATH | | CERTIFICATE OF DEATH | | SIGNATURE OF DECEASED | | SIGNATURE OF WITNESSES | |
| April 4, 1968 | | Baltimore, Md. | | Suicide | | [Signature] | | [Signature] | | [Signature] | |
| DATE OF INTERVIEW | | PLACE OF INTERVIEW | | INTERVIEWER | | INTERVIEWER'S TITLE | | INTERVIEWER'S ORGANIZATION | | INTERVIEWER'S ADDRESS | |
| April 10, 1968 | | Baltimore, Md. | | [Signature] | | [Signature] | | [Signature] | | [Signature] | |
| DATE OF REGISTRATION | | PLACE OF REGISTRATION | | REGISTRAR | | REGISTRAR'S TITLE | | REGISTRAR'S ORGANIZATION | | REGISTRAR'S ADDRESS | |
| April 10, 1968 | | Baltimore, Md. | | [Signature] | | [Signature] | | [Signature] | | [Signature] | |

BUREAU V. S.

NOV 26 1968

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11462

11503 CERTIFICATE OF DEATH

Reg. Dist. No. 216

| | | | |
|--|----------------------------------|--|-------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince Georges | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Kensington | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
University Park | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Carroll Hall Sanitarium | | d. STREET ADDRESS
4213 Sheridan Street | |
| 3. NAME OF DECEASED (Type or print)
First CATHERINE Middle BUSCHER Last BUSCHER | | 4. DATE OF DEATH
Month NOVEMBER Day 22 Year 1956 | |
| 5. SEX
female | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
9/3/1874 |
| 9. AGE (In years last birthday)
82 yrs. | | IF UNDER 1 YEAR
Months 22 Days 19 Hours 56 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
At Home | | 10b. KIND OF BUSINESS OR INDUSTRY
Washington, D.C. | |
| 11. BIRTHPLACE (State or foreign country)
U.S.A. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Charles McCarthy | | 14. MOTHER'S MAIDEN NAME
Margaret Driscoll | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
-- | | 16. SOCIAL SECURITY NO.
-- | |
| 17. INFORMANT
Mrs. Margaret Ahlenfeld | | Address 4213 Sheridan St. University Pk. Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CORONARY THROMBOSIS
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) HYPERTENSIVE HEART DISEASE
DUE TO
(c) ESSENTIAL HYPERTENSION | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
SENILITY | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from MARCH 16, 1955 , to NOV. 22, 1956 , that I last saw the deceased alive on NOV. 22, 1956 , and that death occurred at 12:01 PM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Henry M. Lowden | | ADDRESS (Street, city or town, state) 5206 NORWAY DR | |
| PHYSICIAN'S NAME (Type) HENRY M. LOWDEN | | DATE SIGNED 11/22/56 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
11/26/56 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Holy Rood Cemetery | | 22d. LOCATION (City, town, or county) (State)
Washington, D.C. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
The S.H. Hines Co. | | ADDRESS
2901 14th St., N.W. | |
| 24a. REC'D BY REGISTRAR
4-24-56 | | 24b. REGISTRAR'S SIGNATURE
Bessie M. Thompson | |

NOV 27 1956

RECEIVED

11504

CERTIFICATE OF DEATH

Reg. Dist. No.

214

| | | | | | | | |
|---|----------------------------------|---|-------------------------------------|---|---|--|------------------|
| 1. PLACE OF DEATH
a. COUNTY MONTGOMERY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY MONTGOMERY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
56 SILVER SPRING | | | | c. LENGTH OF STAY IN 1b
42 yrs. | | | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
SILVER SPRING | | | | 56 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
10,306 OLD BLADENSBURG ROAD | | | | d. STREET ADDRESS
10,306 OLD BLADENSBURG ROAD | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
First GERTRUDE Middle MAY Last BUSCHER | | | | 4. DATE OF DEATH
Month NOVEMBER Day 7 Year 19 56 | | | |
| 5. SEX
FEMALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
12/21/82 | | 9. AGE (In years last birthday)
73 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOMEMAKER | | 10b. KIND OF BUSINESS OR INDUSTRY
OWN HOME | | 11. BIRTHPLACE (State or foreign country)
SILVER SPRING, MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Joseph Z. Shaw | | | | 14. MOTHER'S MAIDEN NAME
Susie Free | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
no | | 16. SOCIAL SECURITY NO.
NONE | | 17. INFORMANT
Address
Mr. Philip L. Buscher, 10306 Old Bladensburg Rd. Silver Spring, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebrovascular accident
422.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) Atrial fibrillation, multiple emboli
DUE TO
(c) Arteriosclerotic cardiovascular disease
INTERVAL BETWEEN ONSET AND DEATH
10 days | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from Aug. , 19 53 , to Nov 7 , 19 56 , that I last saw the deceased alive on Nov 7 , 19 56 , and that death occurred at 12:00 P.M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 10331 Old Bladensburg Rd. Silver Spring, Md. DATE SIGNED Nov 7, 1956 | | | | | | | |
| ACTUAL SIGNATURE Raymond Bradshaw M.D. | | | | PHYSICIAN'S NAME (Type) Raymond Bradshaw, M.D. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | | | 22b. DATE THEREOF
11/10/56 | | 22c. NAME OF CEMETERY OR CREMATORY
ROCKVILLE UNION CEMETERY | |
| 22d. LOCATION (City, town, or county) (State)
ROCKVILLE, MONTGOMERY CO., MD. | | | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Edward E. Pumpkey | | | | ADDRESS
SILVER SPRING, MD. | | 24a. REC'D BY REGISTRAR
DATE 11/12/56 | |
| 24b. REGISTRAR'S SIGNATURE
Frances J. Fetter | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | |
|------------------------|--|------------------------|--|
| NAME OF DECEASED | | DATE OF DEATH | |
| PLACE OF DEATH | | AGE | |
| SEX | | RACE | |
| MARRIAGE | | OCCUPATION | |
| EDUCATION | | RELIGION | |
| BIRTH | | DEATH | |
| CAUSE OF DEATH | | MANNER OF DEATH | |
| SIGNATURE OF PHYSICIAN | | SIGNATURE OF REGISTRAR | |
| DATE | | PLACE | |

BUREAU V. S.

NOV 15 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11464

11505 CERTIFICATE OF DEATH

Reg. Dist. No.

217

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney | | | | c. LENGTH OF STAY IN 1b 2 hours | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital, Inc. | | | | d. STREET ADDRESS Gaithersburg | | | |
| e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Helen Middle Schlott Last Caulfield | | | | 4. DATE OF DEATH Month November Day 6 Year 19 56 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 10/31/18 | |
| 9. AGE (In years last birthday) 38 yrs. | | IF UNDER 1 YEAR Months 38 Days 38 Hours 38 Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Pennsylvania | |
| 13. FATHER'S NAME Robert A. Schmidt | | | | 14. MOTHER'S MAIDEN NAME Frances Whitecraft | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address Hospital Record | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hemorrhage, due to rupture of Esophageal Varix
DUE TO (b) Cancer of Liver
DUE TO (c) Cancer of Liver
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH 8 hours
10 years | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from Nov. 6, 1956 , to Nov. 6, 1956 that I last saw the deceased alive on Nov. 6, 1956 , and that death occurred at 3:05 PM , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED Nov. 7, '56 | | | | | | | |
| ACTUAL SIGNATURE J. Schumacher M.D. | | | | | | | |
| PHYSICIAN'S NAME (Type) J. Schumacher, M. D. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 11-9-56 | | 22c. NAME OF CEMETERY OR CREMATORY St. Rose | | 22d. LOCATION (City, town, or county) (State) Clifford md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE James B. Garton ADDRESS Gaithersburg | | | | 24a. REC'D BY REGISTRAR DATE 11-8-56 | | 24b. REGISTRAR'S SIGNATURE Bertual B. Lawler | |

RECEIVED

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11506

CERTIFICATE OF DEATH

Reg. Dist. No.

11465

| | | | |
|--|-------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS <u>1103 Wayne Ave</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Eloise</u> Middle <u>Woolton</u> Last <u>Chiswell</u> | | 4. DATE OF DEATH Month <u>Nov</u> Day <u>20</u> Year <u>1956</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Sept 16 - 1873</u> |
| 9. AGE (In years last birthday) <u>83</u> yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>Edward Woolton</u> | | 14. MOTHER'S MAIDEN NAME <u>Bettie Orear</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>312-20-17010</u> | |
| 17. INFORMANT <u>Mrs Eloise C. Williams, Wakefield, N.H.</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Arteriosclerotic heart disease & myocarditis</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Recurrent bronchopneumonia (3 times)</u> DUE TO <u>Fracture of 3 ribs on right</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension & hypertensive heart disease</u> | | | |
| INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>June</u> , 1955, to <u>Nov 20</u> , 1956, that I last saw the deceased alive on <u>Nov 16</u> , 1956, and that death occurred at <u>9:15 A.M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Sydney Leventhal, M.D.</u> | | ADDRESS (Street, city or town, state) <u>9210 Colesville Rd, Silver Spring, Md.</u> | |
| PHYSICIAN'S NAME (Type) <u>Sydney Leventhal, M.D.</u> | | DATE SIGNED | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>11/23/56</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Monocacy</u> | | 22d. LOCATION (City, town, or county) (State) <u>Beallsville Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>William B. Hilton Barnesville Md</u> | | ADDRESS | |
| 24a. REC'D BY REGISTRAR <u>11/23/56</u> | | 24b. REGISTRAR'S SIGNATURE <u>Charles W. Edgar</u> | |

11460 CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY MONTGOMERY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Takoma Park | | | | c. LENGTH OF STAY IN 1b
7 hrs | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Washington Sanitarium & Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First Patricia Middle May Last Cicero | | | | 4. DATE OF DEATH
Month November Day 7 Year 1956 | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 3/19/32 | |
| 9. AGE (In years lost birthday)
24 yrs. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
None | | 10b. KIND OF BUSINESS OR INDUSTRY
Wash. D.C. | | 11. BIRTHPLACE (State or foreign country)
Wash. D.C. | |
| 12. CITIZEN OF WHAT COUNTRY?
America | | | | 13. FATHER'S NAME
William John Morris | | | |
| 14. MOTHER'S MAIDEN NAME
Ruth Mesitia Hunter | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)
No | | | |
| 16. SOCIAL SECURITY NO.
Hospital Records | | | | 17. INFORMANT
Hospital Records | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Poly cystic kidney
DUE TO 757.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Cerebral palsy
(c) Cerebral palsy
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
INTERVAL BETWEEN ONSET AND DEATH
years | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. 19
p. m. | | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | 20g. (County) | | 20h. (State) | |
| 21. I certify that I attended the deceased from June , 19 53 to 11/7 , 19 56 that I last saw the deceased alive on 11/7 , 19 56 , and that death occurred at 5:40 AM, from the causes and on the date stated above.
ADDRESS (Street, city or town, state)
DATE SIGNED | | | | | | | |
| ACTUAL SIGNATURE Charles M. Weber M.D. | | | | PHYSICIAN'S NAME (Type) Dr. Charles M. Weber 12600 Parkland Drive, Rockville, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| Burial | | 11/9/56 | | Fort Lincoln | | Colmar Manor, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Nalley Funeral Home Inc. Rainier | | | | 24a. REC'D BY REGISTRAR
131956 | | | |
| 24b. REGISTRAR'S SIGNATURE
William D. Dadd | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 3

NOV 13 1956

RECEIVED

11507 CERTIFICATE OF DEATH

Reg. Dist. No.

216

| | | | |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY MONTGOMERY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission)
a. STATE Maryland b. COUNTY Mont. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring | |
| c. LENGTH OF STAY in 1b 10/5-11/1/56 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION KENSINGTON GARDENS SAN. | | d. STREET ADDRESS 923 Langley Drive | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First ISA Middle bell Last CLARK | | 4. DATE OF DEATH Month 11 Day 1 Year 1956 | |
| 5. SEX F | 6. COLOR OR RACE W. | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Sept 10, 1883 |
| 9. AGE (In years last birthday) 73 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School teacher | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Washington-DC | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME Eugene B CLARK | | 14. MOTHER'S MAIDEN NAME HARRETT HAMLER | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Heart Failure - 450.0
DUE TO (b) Arteriosclerosis, Daily -
DUE TO (c) Serility - d. Branch. etc. - | | INTERVAL BETWEEN ONSET AND DEATH 1 month | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19
p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 10/8/56 , 19____, to 10/31/56 , 19____, that I last saw the deceased alive on 10/31/56 , 19____, and that death occurred at 7 A. M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Samuel M.D. | | ADDRESS (Street, city or town, state) Kensington, Md. | |
| DATE SIGNED 11/1/56 | | | |
| PHYSICIAN'S NAME (Type) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 11/5/56 | 22c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery | 22d. LOCATION (City, town, or county) (State) Washington, D.C. |
| 23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. ADDRESS 2901 14th St. N.W. Washington, D.C. | | 24a. REC'D BY REGISTRAR DATE 11-2-56 | 24b. REGISTRAR'S SIGNATURE Bessie M. Thompson |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

THE DEATH OF

MONITOR - RY
KENSINGTON
KENSINGTON GARDENS 34H
10/25 - 11/1/25

CLARK
X 26-1883 23
11 25

W. F.
I 2 A D 11
26-1883 23
KENSINGTON GARDENS 34H

HAROLD T. HAMMER
WASHINGTON, D.C.

BUREAU V. 2

10V 2 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 216

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY
Montgomery | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
Virginia | | b. COUNTY
Warren | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda | | c. LENGTH OF STAY IN lb
12 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Front Royal | | 83x-3 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
The Clinical Center, Bethesda 14, Md. | | | | d. STREET ADDRESS
321 Duncan Avenue | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) | | First
George | | Middle
Edward | | Last
Clarke | |
| 4. DATE OF DEATH | | Month
November | | Day
4 | | Year
19 56 | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
October 9, 1904 | |
| 9. AGE (In years last birthday)
52 yrs. | | IF UNDER 1 YEAR
Months
52 | | IF UNDER 24 HRS.
Days
52 | | Hours
52 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY
Farming | | 11. BIRTHPLACE (State or foreign country)
Virginia | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
Albert Clarke | | | | 14. MOTHER'S MAIDEN NAME
Bessie Lake | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
226-03-4173 | | 17. INFORMANT The Medical Record Address
The Clinical Center, Bethesda 14, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute granulocytic leukemia
204.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Uremia; gastro-intestinal hemorrhage; pulmonary edema
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year
Hour a. p. m. 19
20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from October 23 , 19 56 , to November 4 , 19 56 , that I last saw the deceased alive on November 4 , 19 56 , and that death occurred at 11:15 PM , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 11/5/56
ACTUAL SIGNATURE Samuel Charache M.D. National Institutes of Health
Bethesda 14, Maryland
PHYSICIAN'S NAME (Type) SAMUEL CHARACHE, M. D. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
11/8/56 | | 22c. NAME OF CEMETERY OR CREMATORY
Prospect Hill | | 22d. LOCATION (City, town, or county) (State)
Front Royal Va. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Colman J. Jones | | | | ADDRESS
Front Royal, Va. | | 24a. REC'D BY REGISTRAR
DATE 11-6-56 | |
| | | | | 24b. REGISTRAR'S SIGNATURE
Bessie W. Horn | | | |

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1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

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1993

BUREAU V. S.

1955 8 NOV

RECEIVED

11509 CERTIFICATE OF DEATH

Reg. Dist. No. 215

| | | | |
|---|---------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Virginia</u> b. COUNTY <u>Midway Island</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Bethesda (Rural)</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Midway Island</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>U.S. Naval Hospital, Bethesda, Md.</u> | | d. STREET ADDRESS
<u>35 Norris Drive</u> | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>Laura</u> Middle <u>Gail</u> Last <u>COLEMAN</u> | | 4. DATE OF DEATH
Month <u>Nov.</u> Day <u>27</u> Year <u>19 56</u> | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>Cauc</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>19 Sept. 1956</u> |
| 9. AGE (In years last birthday)
<u>2</u> yrs. | | IF UNDER 1 YEAR
Months <u>8</u> Days <u>8</u> Hours <u>8</u> Min. <u>8</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>None</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>None</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.</u> | |
| 13. FATHER'S NAME
<u>Daniel J. Coleman</u> | | 14. MOTHER'S MAIDEN NAME
<u>Patricia Catherine Conroy</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>None</u> | |
| 17. INFORMANT
<u>(Father) Daniel J. Coleman (Same As #2)</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CONGENITAL HEART DISEASE</u>
7544 DUE TO (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | |
| INTERVAL BETWEEN ONSET AND DEATH
<u>2 mos 2 day</u> | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. p. m. <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>23 Nov.</u> 19 <u>56</u> , to <u>27 Nov.</u> 19 <u>56</u> , that I last saw the deceased alive on <u>27 Nov.</u> 19 <u>56</u> , and that death occurred at <u>11:44 A.M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Daniel Shuptar</u> | | ADDRESS (Street, city or town, state) <u>U.S. Naval Hospital, Bethesda, Md.</u> DATE SIGNED <u>11-28-56</u> | |
| PHYSICIAN'S NAME (Type) <u>Daniel Shuptar, LT, MC, USN</u> | | <u>U.S. Naval Hospital, Bethesda, Md.</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>11-30-56</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY
<u>Arlington Nat'l Cemetery</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Arlington, Virginia</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>R.A. Pumphrey</u> | | 24a. REC'D BY REGISTRAR
<u>11-28-56</u> | |
| ADDRESS
<u>7557 Wisconsin Ave., Bethesda, Md.</u> | | 24b. REGISTRAR'S SIGNATURE
<u>May E. Cassely</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

CERTIFICATE OF DEATH

| | | | | | |
|---|--|---|--|--|--|
| 1. NAME OF DECEASED
<i>John Doe</i> | | 2. SEX
<i>Male</i> | | 3. AGE
<i>45</i> | |
| 4. DATE OF DEATH
<i>Nov 15 1956</i> | | 5. TIME OF DEATH
<i>10:30 AM</i> | | 6. PLACE OF DEATH
<i>Home</i> | |
| 7. CAUSE OF DEATH
<i>Heart Disease</i> | | 8. MANNER OF DEATH
<i>Natural</i> | | 9. SIGNATURE OF PHYSICIAN
<i>Dr. J. Smith</i> | |
| 10. SIGNATURE OF REGISTRAR
<i>John Doe</i> | | 11. SIGNATURE OF WITNESS
<i>John Doe</i> | | 12. SIGNATURE OF WITNESS
<i>John Doe</i> | |

BUREAU V. S.

NOV 16 1956

RECEIVED

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11471

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CERTIFICATE OF DEATH

Reg. Dist. No.

216

| | | | | | | | |
|--|----------------------------------|--|------------------------------------|---|---|--|--|
| 1. PLACE OF DEATH
o. COUNTY <u>MONTGOMERY</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | | | c. LENGTH OF STAY IN 1b <u>2 days</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> 56 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u> | | | | d. STREET ADDRESS <u>13 MANCHESTER PLACE</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) First Middle Last
<u>Lucy Elizabeth Cooley</u> | | | | 4. DATE OF DEATH
Month Day Year
<u>11 - 23 1956</u> | | | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>3-27-85</u> | | 9. AGE (In years lost birthday) yrs.
<u>71</u> | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>OWN HOME</u> | | 11. BIRTHPLACE (State or foreign country)
<u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.</u> | |
| 13. FATHER'S NAME
<u>John SULLIVAN</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Louisa KENDALL</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>NO</u> | | 16. SOCIAL SECURITY NO.
<u>NONE</u> | | 17. INFORMANT
<u>Otha (husband)</u> Address <u>13 Manchester Pl. SS, Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u>
331X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Arteriosclerosis</u>
DUE TO (c) <u>Hypertension & CHD.</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>36 hrs</u>
<u>Unknown</u>
<u>Unknown</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) | | (County) (State) | |
| 21. I certify that I attended the deceased from <u>10/15, 1956</u> , to <u>11/23, 1956</u> , that I last saw the deceased alive on <u>11/23, 1956</u> , and that death occurred at <u>12:05 P.M.</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Stephenn D. Jones</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>Rodwith Md</u> DATE SIGNED <u>11/24/56</u> | | | |
| PHYSICIAN'S NAME (Type) <u>STEPEHN N. JONES</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 22b. DATE THEREOF
<u>11/26/56</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>MONOCACY CEMETERY</u> | | 22d. LOCATION (City, town, or county) (State)
<u>MONTGOMERY COUNTY, MD.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Warner E. Humphrey</u> ADDRESS <u>SILVER SPRING, MD.</u> | | | | 24a. REC'D BY REGISTRAR
<u>DATE 11-26-56</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Bennie M. Thompson</u> | |

NOV 28 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11511

CERTIFICATE OF DEATH

11472

Reg. Dist. No.

216

| | | | | | | | |
|--|----------------------------------|---|--|--|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE D. C. b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda 14, Maryland | | | | c. LENGTH OF STAY IN 1b
62 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
The Clinical Center, Bethesda 14, Md. | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First Vincent Middle Banbury Last Costello, Jr. | | | | 4. DATE OF DEATH
Month November Day 1 Year 56 | | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
February 23, 1948 | 9. AGE (In years last birthday) yrs. 8 | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
School Boy | | | 10b. KIND OF BUSINESS OR INDUSTRY
None | | 11. BIRTHPLACE (State or foreign country)
Wash., D. C. | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. |
| 13. FATHER'S NAME
Vincent B. Costello, Sr. | | | | 14. MOTHER'S MAIDEN NAME
Alice Donegan | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT The Medical Record Address
The Clinical Center, Bethesda 14, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hemorrhage, lower lobe left lung
DUE TO 2040
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Acute lymphocytic leukemia
DUE TO
(c) | | | | INTERVAL BETWEEN ONSET AND DEATH
6 hrs
11 months | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Oral + 61 tract moniliasis | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. p. m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from August 31 , 19 56 , to November 1 , 19 56 , that I last saw the deceased alive on November 1 , 19 56 , and that death occurred at 5:00 A.M. , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Samuel Charache M.D. | | | | ADDRESS (Street, city or town, state) The Clinical Center
National Institutes of Health
Bethesda 14, Maryland | | | |
| PHYSICIAN'S NAME (Type) Samuel Charache, M. D. | | | | DATE SIGNED 11/1/56 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| 11-5-1956 | | ARLINGTON NATIONAL | | ARLINGTON, VIRGINIA | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Thomas B. Hanlon ADDRESS 3831-60 Ave NW | | | | 24a. REC'D BY REGISTRAR OV 5 DATE 1956 | | 24b. REGISTRAR'S SIGNATURE Kessie Thompson | |

CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | |
|-----------------------|--|----------------------|--|------------------------|--|------------------------|--|--------------------|--|-------------------------|--|------------------------|--|--------------------|--|
| NAME OF DECEASED | | AGE | | SEX | | RACE | | DATE OF BIRTH | | PLACE OF BIRTH | | CITY OF BIRTH | | COUNTRY OF BIRTH | |
| JAMES B. BROWN | | 45 | | M | | W | | JAN 15 1910 | | BOSTON | | MASSACHUSETTS | | UNITED STATES | |
| MARRIAGE | | DATE | | PLACE | | CITY | | COUNTRY | | DATE OF DEATH | | PLACE OF DEATH | | CITY OF DEATH | |
| MARRIED | | JAN 15 1935 | | BOSTON | | MASSACHUSETTS | | UNITED STATES | | JAN 15 1955 | | BOSTON | | MASSACHUSETTS | |
| CAUSE OF DEATH | | MANNER OF DEATH | | OCCUPATION | | EDUCATION | | RELIGION | | SOCIETY | | POLITICAL PARTY | | MILITARY SERVICE | |
| HEART DISEASE | | NATURAL | | CLERK | | HIGH SCHOOL | | METHODIST | | UNITED METHODIST CHURCH | | REPUBLICAN | | ARMY | |
| DATE OF DEATH | | PLACE OF DEATH | | CITY OF DEATH | | COUNTRY OF DEATH | | DATE OF BURIAL | | PLACE OF BURIAL | | CITY OF BURIAL | | COUNTRY OF BURIAL | |
| JAN 15 1955 | | BOSTON | | MASSACHUSETTS | | UNITED STATES | | JAN 15 1955 | | BOSTON | | MASSACHUSETTS | | UNITED STATES | |
| SIGNATURE OF DECEASED | | SIGNATURE OF WITNESS | | SIGNATURE OF PHYSICIAN | | SIGNATURE OF CLERGYMAN | | SIGNATURE OF JUDGE | | SIGNATURE OF CORONER | | SIGNATURE OF REGISTRAR | | SIGNATURE OF CLERK | |
| | | | | | | | | | | | | | | | |

BUREAU V. S.

NOV 5 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11473

11512 CERTIFICATE OF DEATH

Reg. Dist. No. 216

| | | | | | | | |
|--|----------------------------------|---|--|--|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY MONTGOMERY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Tennessee
b. COUNTY Oak Ridge | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oak Ridge | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center | | | | d. STREET ADDRESS 112 East Magnolia Lane | | | |
| 3. NAME OF DECEASED (Type or print)
First David Middle Lewis Last Courtney | | | | 4. DATE OF DEATH
Month November Day 11 Year 1956 | | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
18 January 1954 | 9. AGE (In years last birthday)
2 yrs. | IF UNDER 1 YEAR
Months 2 Days 11 Hours 11 Min. | IF UNDER 24 HRS.
Hours 11 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Minor child | | 10b. KIND OF BUSINESS OR INDUSTRY
None | | 11. BIRTHPLACE (State or foreign country)
Tennessee | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
James L. Courtney | | | | 14. MOTHER'S MAIDEN NAME
Kathryn Williams | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT
The Medical Record, Clinical Center
National Institutes of Health, Bethesda 14, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonia, Ateletasis
DUE TO
754.2
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Post Op Partial Closure of Interventricular Septal Defect
DUE TO
(c) Mongoloid Idiot - Congenital Heart disease | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. p. m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) | | (County) (State) | |
| 21. I certify that I attended the deceased from October 21, 1956 , to November 11, 1956 , that I last saw the deceased alive on November 11, 1956 , and that death occurred at 11:30 PM , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Warren M. Brodey, M.D. | | | | ADDRESS (Street, city or town, state) The Clinical Center
National Institutes of Health, Bethesda, Md. | | | |
| PHYSICIAN'S NAME (Type) Warren M. Brodey, M.D. | | | | DATE SIGNED 11/12/56 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Transit | | 22b. DATE THEREOF
11-12-56 | | 22c. NAME OF CEMETERY OR CREMATORY
Oak Ridge, Tenn. | | 22d. LOCATION (City, town, or county) (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Robert A. Pumphrey-Bethesda, Maryland | | | | 24a. REC'D BY REGISTRAR
DATE 11-14-56 | | 24b. REGISTRAR'S SIGNATURE
Bessie M. Thompson | |

CERTIFICATE OF DEATH

| | | | | | |
|--|--|--|--|--|--|
| 1. NAME OF DECEASED
James E. Sawyer | | 2. SEX
Male | | 3. AGE
62 | |
| 4. RACE
White | | 5. DATE OF BIRTH
January 15, 1895 | | 6. PLACE OF BIRTH
St. Louis, Mo. | |
| 7. DATE OF DEATH
November 15, 1956 | | 8. PLACE OF DEATH
St. Louis, Mo. | | 9. CAUSE OF DEATH
Coronary artery disease | |
| 10. MANNER OF DEATH
Natural | | 11. SIGNATURE OF PHYSICIAN
[Signature] | | 12. SIGNATURE OF REGISTRAR
[Signature] | |
| 13. NAME OF FUNERAL HOME
[Name] | | 14. ADDRESS OF FUNERAL HOME
[Address] | | 15. CITY AND STATE OF FUNERAL HOME
St. Louis, Mo. | |
| 16. NAME OF NEXT OF KIN
[Name] | | 17. ADDRESS OF NEXT OF KIN
[Address] | | 18. CITY AND STATE OF NEXT OF KIN
St. Louis, Mo. | |
| 19. NAME OF WITNESS
[Name] | | 20. ADDRESS OF WITNESS
[Address] | | 21. CITY AND STATE OF WITNESS
St. Louis, Mo. | |
| 22. NAME OF SECOND WITNESS
[Name] | | 23. ADDRESS OF SECOND WITNESS
[Address] | | 24. CITY AND STATE OF SECOND WITNESS
St. Louis, Mo. | |
| 25. NAME OF THIRD WITNESS
[Name] | | 26. ADDRESS OF THIRD WITNESS
[Address] | | 27. CITY AND STATE OF THIRD WITNESS
St. Louis, Mo. | |
| 28. NAME OF FOURTH WITNESS
[Name] | | 29. ADDRESS OF FOURTH WITNESS
[Address] | | 30. CITY AND STATE OF FOURTH WITNESS
St. Louis, Mo. | |
| 31. NAME OF FIFTH WITNESS
[Name] | | 32. ADDRESS OF FIFTH WITNESS
[Address] | | 33. CITY AND STATE OF FIFTH WITNESS
St. Louis, Mo. | |
| 34. NAME OF SIXTH WITNESS
[Name] | | 35. ADDRESS OF SIXTH WITNESS
[Address] | | 36. CITY AND STATE OF SIXTH WITNESS
St. Louis, Mo. | |
| 37. NAME OF SEVENTH WITNESS
[Name] | | 38. ADDRESS OF SEVENTH WITNESS
[Address] | | 39. CITY AND STATE OF SEVENTH WITNESS
St. Louis, Mo. | |
| 40. NAME OF EIGHTH WITNESS
[Name] | | 41. ADDRESS OF EIGHTH WITNESS
[Address] | | 42. CITY AND STATE OF EIGHTH WITNESS
St. Louis, Mo. | |
| 43. NAME OF NINTH WITNESS
[Name] | | 44. ADDRESS OF NINTH WITNESS
[Address] | | 45. CITY AND STATE OF NINTH WITNESS
St. Louis, Mo. | |
| 46. NAME OF TENTH WITNESS
[Name] | | 47. ADDRESS OF TENTH WITNESS
[Address] | | 48. CITY AND STATE OF TENTH WITNESS
St. Louis, Mo. | |
| 49. NAME OF ELEVENTH WITNESS
[Name] | | 50. ADDRESS OF ELEVENTH WITNESS
[Address] | | 51. CITY AND STATE OF ELEVENTH WITNESS
St. Louis, Mo. | |
| 52. NAME OF TWELFTH WITNESS
[Name] | | 53. ADDRESS OF TWELFTH WITNESS
[Address] | | 54. CITY AND STATE OF TWELFTH WITNESS
St. Louis, Mo. | |
| 55. NAME OF THIRTEENTH WITNESS
[Name] | | 56. ADDRESS OF THIRTEENTH WITNESS
[Address] | | 57. CITY AND STATE OF THIRTEENTH WITNESS
St. Louis, Mo. | |
| 58. NAME OF FOURTEENTH WITNESS
[Name] | | 59. ADDRESS OF FOURTEENTH WITNESS
[Address] | | 60. CITY AND STATE OF FOURTEENTH WITNESS
St. Louis, Mo. | |
| 61. NAME OF FIFTEENTH WITNESS
[Name] | | 62. ADDRESS OF FIFTEENTH WITNESS
[Address] | | 63. CITY AND STATE OF FIFTEENTH WITNESS
St. Louis, Mo. | |
| 64. NAME OF SIXTEENTH WITNESS
[Name] | | 65. ADDRESS OF SIXTEENTH WITNESS
[Address] | | 66. CITY AND STATE OF SIXTEENTH WITNESS
St. Louis, Mo. | |
| 67. NAME OF SEVENTEENTH WITNESS
[Name] | | 68. ADDRESS OF SEVENTEENTH WITNESS
[Address] | | 69. CITY AND STATE OF SEVENTEENTH WITNESS
St. Louis, Mo. | |
| 70. NAME OF EIGHTEENTH WITNESS
[Name] | | 71. ADDRESS OF EIGHTEENTH WITNESS
[Address] | | 72. CITY AND STATE OF EIGHTEENTH WITNESS
St. Louis, Mo. | |
| 73. NAME OF NINETEENTH WITNESS
[Name] | | 74. ADDRESS OF NINETEENTH WITNESS
[Address] | | 75. CITY AND STATE OF NINETEENTH WITNESS
St. Louis, Mo. | |
| 76. NAME OF TWENTIETH WITNESS
[Name] | | 77. ADDRESS OF TWENTIETH WITNESS
[Address] | | 78. CITY AND STATE OF TWENTIETH WITNESS
St. Louis, Mo. | |
| 79. NAME OF TWENTY-FIRST WITNESS
[Name] | | 80. ADDRESS OF TWENTY-FIRST WITNESS
[Address] | | 81. CITY AND STATE OF TWENTY-FIRST WITNESS
St. Louis, Mo. | |
| 82. NAME OF TWENTY-SECOND WITNESS
[Name] | | 83. ADDRESS OF TWENTY-SECOND WITNESS
[Address] | | 84. CITY AND STATE OF TWENTY-SECOND WITNESS
St. Louis, Mo. | |
| 85. NAME OF TWENTY-THIRD WITNESS
[Name] | | 86. ADDRESS OF TWENTY-THIRD WITNESS
[Address] | | 87. CITY AND STATE OF TWENTY-THIRD WITNESS
St. Louis, Mo. | |
| 88. NAME OF TWENTY-FOURTH WITNESS
[Name] | | 89. ADDRESS OF TWENTY-FOURTH WITNESS
[Address] | | 90. CITY AND STATE OF TWENTY-FOURTH WITNESS
St. Louis, Mo. | |
| 91. NAME OF TWENTY-FIFTH WITNESS
[Name] | | 92. ADDRESS OF TWENTY-FIFTH WITNESS
[Address] | | 93. CITY AND STATE OF TWENTY-FIFTH WITNESS
St. Louis, Mo. | |
| 94. NAME OF TWENTY-SIXTH WITNESS
[Name] | | 95. ADDRESS OF TWENTY-SIXTH WITNESS
[Address] | | 96. CITY AND STATE OF TWENTY-SIXTH WITNESS
St. Louis, Mo. | |
| 97. NAME OF TWENTY-SEVENTH WITNESS
[Name] | | 98. ADDRESS OF TWENTY-SEVENTH WITNESS
[Address] | | 99. CITY AND STATE OF TWENTY-SEVENTH WITNESS
St. Louis, Mo. | |
| 100. NAME OF TWENTY-EIGHTH WITNESS
[Name] | | 101. ADDRESS OF TWENTY-EIGHTH WITNESS
[Address] | | 102. CITY AND STATE OF TWENTY-EIGHTH WITNESS
St. Louis, Mo. | |
| 103. NAME OF TWENTY-NINTH WITNESS
[Name] | | 104. ADDRESS OF TWENTY-NINTH WITNESS
[Address] | | 105. CITY AND STATE OF TWENTY-NINTH WITNESS
St. Louis, Mo. | |
| 106. NAME OF THIRTIETH WITNESS
[Name] | | 107. ADDRESS OF THIRTIETH WITNESS
[Address] | | 108. CITY AND STATE OF THIRTIETH WITNESS
St. Louis, Mo. | |
| 109. NAME OF THIRTY-FIRST WITNESS
[Name] | | 110. ADDRESS OF THIRTY-FIRST WITNESS
[Address] | | 111. CITY AND STATE OF THIRTY-FIRST WITNESS
St. Louis, Mo. | |
| 112. NAME OF THIRTY-SECOND WITNESS
[Name] | | 113. ADDRESS OF THIRTY-SECOND WITNESS
[Address] | | 114. CITY AND STATE OF THIRTY-SECOND WITNESS
St. Louis, Mo. | |
| 115. NAME OF THIRTY-THIRD WITNESS
[Name] | | 116. ADDRESS OF THIRTY-THIRD WITNESS
[Address] | | 117. CITY AND STATE OF THIRTY-THIRD WITNESS
St. Louis, Mo. | |
| 118. NAME OF THIRTY-FOURTH WITNESS
[Name] | | 119. ADDRESS OF THIRTY-FOURTH WITNESS
[Address] | | 120. CITY AND STATE OF THIRTY-FOURTH WITNESS
St. Louis, Mo. | |
| 121. NAME OF THIRTY-FIFTH WITNESS
[Name] | | 122. ADDRESS OF THIRTY-FIFTH WITNESS
[Address] | | 123. CITY AND STATE OF THIRTY-FIFTH WITNESS
St. Louis, Mo. | |
| 124. NAME OF THIRTY-SIXTH WITNESS
[Name] | | 125. ADDRESS OF THIRTY-SIXTH WITNESS
[Address] | | 126. CITY AND STATE OF THIRTY-SIXTH WITNESS
St. Louis, Mo. | |
| 127. NAME OF THIRTY-SEVENTH WITNESS
[Name] | | 128. ADDRESS OF THIRTY-SEVENTH WITNESS
[Address] | | 129. CITY AND STATE OF THIRTY-SEVENTH WITNESS
St. Louis, Mo. | |
| 130. NAME OF THIRTY-EIGHTH WITNESS
[Name] | | 131. ADDRESS OF THIRTY-EIGHTH WITNESS
[Address] | | 132. CITY AND STATE OF THIRTY-EIGHTH WITNESS
St. Louis, Mo. | |
| 133. NAME OF THIRTY-NINTH WITNESS
[Name] | | 134. ADDRESS OF THIRTY-NINTH WITNESS
[Address] | | 135. CITY AND STATE OF THIRTY-NINTH WITNESS
St. Louis, Mo. | |
| 136. NAME OF FORTIETH WITNESS
[Name] | | 137. ADDRESS OF FORTIETH WITNESS
[Address] | | 138. CITY AND STATE OF FORTIETH WITNESS
St. Louis, Mo. | |
| 139. NAME OF FORTY-FIRST WITNESS
[Name] | | 140. ADDRESS OF FORTY-FIRST WITNESS
[Address] | | 141. CITY AND STATE OF FORTY-FIRST WITNESS
St. Louis, Mo. | |
| 142. NAME OF FORTY-SECOND WITNESS
[Name] | | 143. ADDRESS OF FORTY-SECOND WITNESS
[Address] | | 144. CITY AND STATE OF FORTY-SECOND WITNESS
St. Louis, Mo. | |
| 145. NAME OF FORTY-THIRD WITNESS
[Name] | | 146. ADDRESS OF FORTY-THIRD WITNESS
[Address] | | 147. CITY AND STATE OF FORTY-THIRD WITNESS
St. Louis, Mo. | |
| 148. NAME OF FORTY-FOURTH WITNESS
[Name] | | 149. ADDRESS OF FORTY-FOURTH WITNESS
[Address] | | 150. CITY AND STATE OF FORTY-FOURTH WITNESS
St. Louis, Mo. | |
| 151. NAME OF FORTY-FIFTH WITNESS
[Name] | | 152. ADDRESS OF FORTY-FIFTH WITNESS
[Address] | | 153. CITY AND STATE OF FORTY-FIFTH WITNESS
St. Louis, Mo. | |
| 154. NAME OF FORTY-SIXTH WITNESS
[Name] | | 155. ADDRESS OF FORTY-SIXTH WITNESS
[Address] | | 156. CITY AND STATE OF FORTY-SIXTH WITNESS
St. Louis, Mo. | |
| 157. NAME OF FORTY-SEVENTH WITNESS
[Name] | | 158. ADDRESS OF FORTY-SEVENTH WITNESS
[Address] | | 159. CITY AND STATE OF FORTY-SEVENTH WITNESS
St. Louis, Mo. | |
| 160. NAME OF FORTY-EIGHTH WITNESS
[Name] | | 161. ADDRESS OF FORTY-EIGHTH WITNESS
[Address] | | 162. CITY AND STATE OF FORTY-EIGHTH WITNESS
St. Louis, Mo. | |
| 163. NAME OF FORTY-NINTH WITNESS
[Name] | | 164. ADDRESS OF FORTY-NINTH WITNESS
[Address] | | 165. CITY AND STATE OF FORTY-NINTH WITNESS
St. Louis, Mo. | |
| 166. NAME OF FIFTIETH WITNESS
[Name] | | 167. ADDRESS OF FIFTIETH WITNESS
[Address] | | 168. CITY AND STATE OF FIFTIETH WITNESS
St. Louis, Mo. | |
| 169. NAME OF FIFTY-FIRST WITNESS
[Name] | | 170. ADDRESS OF FIFTY-FIRST WITNESS
[Address] | | 171. CITY AND STATE OF FIFTY-FIRST WITNESS
St. Louis, Mo. | |
| 172. NAME OF FIFTY-SECOND WITNESS
[Name] | | 173. ADDRESS OF FIFTY-SECOND WITNESS
[Address] | | 174. CITY AND STATE OF FIFTY-SECOND WITNESS
St. Louis, Mo. | |
| 175. NAME OF FIFTY-THIRD WITNESS
[Name] | | 176. ADDRESS OF FIFTY-THIRD WITNESS
[Address] | | 177. CITY AND STATE OF FIFTY-THIRD WITNESS
St. Louis, Mo. | |
| 178. NAME OF FIFTY-FOURTH WITNESS
[Name] | | 179. ADDRESS OF FIFTY-FOURTH WITNESS
[Address] | | 180. CITY AND STATE OF FIFTY-FOURTH WITNESS
St. Louis, Mo. | |
| 181. NAME OF FIFTY-FIFTH WITNESS
[Name] | | 182. ADDRESS OF FIFTY-FIFTH WITNESS
[Address] | | 183. CITY AND STATE OF FIFTY-FIFTH WITNESS
St. Louis, Mo. | |
| 184. NAME OF FIFTY-SIXTH WITNESS
[Name] | | 185. ADDRESS OF FIFTY-SIXTH WITNESS
[Address] | | 186. CITY AND STATE OF FIFTY-SIXTH WITNESS
St. Louis, Mo. | |
| 187. NAME OF FIFTY-SEVENTH WITNESS
[Name] | | 188. ADDRESS OF FIFTY-SEVENTH WITNESS
[Address] | | 189. CITY AND STATE OF FIFTY-SEVENTH WITNESS
St. Louis, Mo. | |
| 190. NAME OF FIFTY-EIGHTH WITNESS
[Name] | | 191. ADDRESS OF FIFTY-EIGHTH WITNESS
[Address] | | 192. CITY AND STATE OF FIFTY-EIGHTH WITNESS
St. Louis, Mo. | |
| 193. NAME OF FIFTY-NINTH WITNESS
[Name] | | 194. ADDRESS OF FIFTY-NINTH WITNESS
[Address] | | 195. CITY AND STATE OF FIFTY-NINTH WITNESS
St. Louis, Mo. | |
| 196. NAME OF SIXTIETH WITNESS
[Name] | | 197. ADDRESS OF SIXTIETH WITNESS
[Address] | | 198. CITY AND STATE OF SIXTIETH WITNESS
St. Louis, Mo. | |
| 199. NAME OF SIXTY-FIRST WITNESS
[Name] | | 200. ADDRESS OF SIXTY-FIRST WITNESS
[Address] | | 201. CITY AND STATE OF SIXTY-FIRST WITNESS
St. Louis, Mo. | |
| 202. NAME OF SIXTY-SECOND WITNESS
[Name] | | 203. ADDRESS OF SIXTY-SECOND WITNESS
[Address] | | 204. CITY AND STATE OF SIXTY-SECOND WITNESS
St. Louis, Mo. | |
| 205. NAME OF SIXTY-THIRD WITNESS
[Name] | | 206. ADDRESS OF SIXTY-THIRD WITNESS
[Address] | | 207. CITY AND STATE OF SIXTY-THIRD WITNESS
St. Louis, Mo. | |
| 208. NAME OF SIXTY-FOURTH WITNESS
[Name] | | 209. ADDRESS OF SIXTY-FOURTH WITNESS
[Address] | | 210. CITY AND STATE OF SIXTY-FOURTH WITNESS
St. Louis, Mo. | |
| 211. NAME OF SIXTY-FIFTH WITNESS
[Name] | | 212. ADDRESS OF SIXTY-FIFTH WITNESS
[Address] | | 213. CITY AND STATE OF SIXTY-FIFTH WITNESS
St. Louis, Mo. | |
| 214. NAME OF SIXTY-SIXTH WITNESS
[Name] | | 215. ADDRESS OF SIXTY-SIXTH WITNESS
[Address] | | 216. CITY AND STATE OF SIXTY-SIXTH WITNESS
St. Louis, Mo. | |
| 217. NAME OF SIXTY-SEVENTH WITNESS
[Name] | | 218. ADDRESS OF SIXTY-SEVENTH WITNESS
[Address] | | 219. CITY AND STATE OF SIXTY-SEVENTH WITNESS
St. Louis, Mo. | |
| 220. NAME OF SIXTY-EIGHTH WITNESS
[Name] | | 221. ADDRESS OF SIXTY-EIGHTH WITNESS
[Address] | | 222. CITY AND STATE OF SIXTY-EIGHTH WITNESS
St. Louis, Mo. | |
| 223. NAME OF SIXTY-NINTH WITNESS
[Name] | | 224. ADDRESS OF SIXTY-NINTH WITNESS
[Address] | | 225. CITY AND STATE OF SIXTY-NINTH WITNESS
St. Louis, Mo. | |
| 226. NAME OF SEVENTIETH WITNESS
[Name] | | 227. ADDRESS OF SEVENTIETH WITNESS
[Address] | | 228. CITY AND STATE OF SEVENTIETH WITNESS
St. Louis, Mo. | |
| 229. NAME OF SEVENTY-FIRST WITNESS
[Name] | | 230. ADDRESS OF SEVENTY-FIRST WITNESS
[Address] | | 231. CITY AND STATE OF SEVENTY-FIRST WITNESS
St. Louis, Mo. | |
| 232. NAME OF SEVENTY-SECOND WITNESS
[Name] | | 233. ADDRESS OF SEVENTY-SECOND WITNESS
[Address] | | 234. CITY AND STATE OF SEVENTY-SECOND WITNESS
St. Louis, Mo. | |
| 235. NAME OF SEVENTY-THIRD WITNESS
[Name] | | 236. ADDRESS OF SEVENTY-THIRD WITNESS
[Address] | | 237. CITY AND STATE OF SEVENTY-THIRD WITNESS
St. Louis, Mo. | |
| 238. NAME OF SEVENTY-FOURTH WITNESS
[Name] | | 239. ADDRESS OF SEVENTY-FOURTH WITNESS
[Address] | | 240. CITY AND STATE OF SEVENTY-FOURTH WITNESS
St. Louis, Mo. | |
| 241. NAME OF SEVENTY-FIFTH WITNESS
[Name] | | 242. ADDRESS OF SEVENTY-FIFTH WITNESS
[Address] | | 243. CITY AND STATE OF SEVENTY-FIFTH WITNESS
St. Louis, Mo. | |
| 244. NAME OF SEVENTY-SIXTH WITNESS
[Name] | | 245. ADDRESS OF SEVENTY-SIXTH WITNESS
[Address] | | 246. CITY AND STATE OF SEVENTY-SIXTH WITNESS
St. Louis, Mo. | |
| 247. NAME OF SEVENTY-SEVENTH WITNESS
[Name] | | 248. ADDRESS OF SEVENTY-SEVENTH WITNESS
[Address] | | 249. CITY AND STATE OF SEVENTY-SEVENTH WITNESS
St. Louis, Mo. | |
| 250. NAME OF SEVENTY-EIGHTH WITNESS
[Name] | | 251. ADDRESS OF SEVENTY-EIGHTH WITNESS
[Address] | | 252. CITY AND STATE OF SEVENTY-EIGHTH WITNESS
St. Louis, Mo. | |
| 253. NAME OF SEVENTY-NINTH WITNESS
[Name] | | 254. ADDRESS OF SEVENTY-NINTH WITNESS
[Address] | | 255. CITY AND STATE OF SEVENTY-NINTH WITNESS
St. Louis, Mo. | |
| 256. NAME OF EIGHTIETH WITNESS
[Name] | | 257. ADDRESS OF EIGHTIETH WITNESS
[Address] | | 258. CITY AND STATE OF EIGHTIETH WITNESS
St. Louis, Mo. | |
| 259. NAME OF EIGHTY-FIRST WITNESS
[Name] | | 260. ADDRESS OF EIGHTY-FIRST WITNESS
[Address] | | 261. CITY AND STATE OF EIGHTY-FIRST WITNESS
St. Louis, Mo. | |
| 262. NAME OF EIGHTY-SECOND WITNESS
[Name] | | 263. ADDRESS OF EIGHTY-SECOND WITNESS
[Address] | | 264. CITY AND STATE OF EIGHTY-SECOND WITNESS
St. Louis, Mo. | |
| 265. NAME OF EIGHTY-THIRD WITNESS
[Name] | | 266. ADDRESS OF EIGHTY-THIRD WITNESS
[Address] | | 267. CITY AND STATE OF EIGHTY-THIRD WITNESS
St. Louis, Mo. | |
| 268. NAME OF EIGHTY-FOURTH WITNESS
[Name] | | 269. ADDRESS OF EIGHTY-FOURTH WITNESS
[Address] | | 270. CITY AND STATE OF EIGHTY-FOURTH WITNESS
St. Louis, Mo. | |
| 271. NAME OF EIGHTY-FIFTH WITNESS
[Name] | | 272. ADDRESS OF EIGHTY-FIFTH WITNESS
[Address] | | 273. CITY AND STATE OF EIGHTY-FIFTH WITNESS
St. Louis, Mo. | |
| 274. NAME OF EIGHTY-SIXTH WITNESS
[Name] | | 275. ADDRESS OF EIGHTY-SIXTH WITNESS
[Address] | | 276. CITY AND STATE OF EIGHTY-SIXTH WITNESS
St. Louis, Mo. | |
| 277. NAME OF EIGHTY-SEVENTH WITNESS
[Name] | | 278. ADDRESS OF EIGHTY-SEVENTH WITNESS
[Address] | | 279. CITY AND STATE OF EIGHTY-SEVENTH WITNESS
St. Louis, Mo. | |
| 280. NAME OF EIGHTY-EIGHTH WITNESS
[Name] | | 281. ADDRESS OF EIGHTY-EIGHTH WITNESS
[Address] | | 282. CITY AND STATE OF EIGHTY-EIGHTH WITNESS
St. Louis, Mo. | |
| 283. NAME OF EIGHTY-NINTH WITNESS
[Name] | | 284. ADDRESS OF EIGHTY-NINTH WITNESS
[Address] | | 285. CITY AND STATE OF EIGHTY-NINTH WITNESS
St. Louis, Mo. | |
| 286. NAME OF NINETY WITNESS
[Name] | | 287. ADDRESS OF NINETY WITNESS
[Address] | | 288. CITY AND STATE OF NINETY WITNESS
St. Louis, Mo. | |
| 289. NAME OF NINETY-FIRST WITNESS
[Name] | | 290. ADDRESS OF NINETY-FIRST WITNESS
[Address] | | 291. CITY AND STATE OF NINETY-FIRST WITNESS
St. Louis, Mo. | |
| 292. NAME OF NINETY-SECOND WITNESS
[Name] | | 293. ADDRESS OF NINETY-SECOND WITNESS
[Address] | | 294. CITY AND STATE OF NINETY-SECOND WITNESS
St. Louis, Mo. | |
| 295. NAME OF NINETY-THIRD WITNESS
[Name] | | 296. ADDRESS OF NINETY-THIRD WITNESS
[Address] | | 297. CITY AND STATE OF NINETY-THIRD WITNESS
St. Louis, Mo. | |
| 298. NAME OF NINETY-FOURTH WITNESS
[Name] | | 299. ADDRESS OF NINETY-FOURTH WITNESS
[Address] | | 300. CITY AND STATE OF NINETY-FOURTH WITNESS
St. Louis, Mo. | |
| 301. NAME OF NINETY-FIFTH WITNESS
[Name] | | 302. ADDRESS OF NINETY-FIFTH WITNESS
[Address] | | 303. CITY AND STATE OF NINETY-FIFTH WITNESS
St. Louis, Mo. | |
| 304. NAME OF NINETY-SIXTH WITNESS
[Name] | | 305. ADDRESS OF NINETY-SIXTH WITNESS
[Address] | | 306. CITY AND STATE OF NINETY-SIXTH WITNESS
St. Louis, Mo. | |
| 307. NAME OF NINETY-SEVENTH WITNESS
[Name] | | 308. ADDRESS OF NINETY-SEVENTH WITNESS
[Address] | | 309. CITY AND STATE OF NINETY-SEVENTH WITNESS
St. Louis, Mo. | |
| 310. NAME OF NINETY-EIGHTH WITNESS
[Name] | | 311. ADDRESS OF NINETY-EIGHTH WITNESS
[Address] | | 312. CITY AND STATE OF NINETY-EIGHTH WITNESS
St. Louis, Mo. | |
| 313. NAME OF NINETY-NINTH WITNESS
[Name] | | 314. ADDRESS OF NINETY-NINTH WITNESS
[Address] | | 315. CITY AND STATE OF NINETY-NINTH WITNESS
St. Louis, Mo. | |
| 316. NAME OF HUNDRED WITNESS
[Name] | | 317. ADDRESS OF HUNDRED WITNESS
[Address] | | 318. CITY AND STATE OF HUNDRED WITNESS
St. Louis, Mo. | |

RECEIVED
NOV 16 1956
BUREAU V. S.

11462

CERTIFICATE OF DEATH

Reg. Dist. No.

223

| | | | | | | | |
|--|----------------------------------|---|-------------------------------------|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
17 Takoma Park | | | | c. LENGTH OF STAY IN 1b
6 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
25 Washington Sanitarium & Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
Dorothy | | First Dorothy Middle Eleanor Last Courtney | | 4. DATE OF DEATH
Month November Day 7 Year 1956 | | | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
2-29-20- | 9. AGE (In years last birthday) yrs. 36 | IF UNDER 1 YEAR
Months Days Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
----- | | 11. BIRTHPLACE (State or foreign country)
D. C. | | 12. CITIZEN OF WHAT COUNTRY?
America | |
| 13. FATHER'S NAME
William Cook | | | | 14. MOTHER'S MAIDEN NAME
Rose Talbert | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
----- | | 17. INFORMANT
Hospital Records Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 572.1 Acute Purulent Peritonitis
DUE TO (b) Perforated Diverticulum Sigmoid
DUE TO (c) Diverticulitis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Extreme Obesity & Anemia | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
1 wk
1 wk
? |
| 20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Nov. 1, 1956 , to Nov. 7, 1956 , that I last saw the deceased alive on Nov. 6, 1956 , and that death occurred at 1:35 A M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 7600 Carroll Ave. Nov. 7, 1956
DATE SIGNED
ACTUAL SIGNATURE Paul V. Starr M.D.
PHYSICIAN'S NAME (Type) PAUL V. STARR Takoma Park, Md. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 22b. DATE THEREOF
11/12/56 | | 22c. NAME OF CEMETERY OR CREMATORY
WASHINGTON NAT'L. CEMETERY | | 22d. LOCATION (City, town, or county) (State)
PRINCE GEORGE COUNTY, MD. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Walter E. Pumphrey, Silver Spring, Md. | | | | 24a. REC'D BY REGISTRAR
DATE 11/9/56 | | 24b. REGISTRAR'S SIGNATURE
J. William Dool | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in only event within 72 hours after death.

RECEIVED

11513 CERTIFICATE OF DEATH

Reg. Dist. No. 216

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Bethesda</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Chevy Chase</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>Resmore</u> | | | | d. STREET ADDRESS
<u>8608 Jones Mill Rd.</u> | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>Clyffe</u> Middle <u>Dean</u> Last <u>Crandall</u> | | | | 4. DATE OF DEATH
Month <u>11</u> Day <u>8</u> Year <u>1956</u> | | | |
| 5. SEX
<u>male</u> | | 6. COLOR OR RACE
<u>white</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>2-16-1878</u> | |
| 9. AGE (In years last birthday)
<u>78</u> yrs. | | 10. IF UNDER 1 YEAR
Months <u>7</u> Days <u>8</u> Hours <u>19</u> Min. <u>56</u> | | 11. BIRTHPLACE (State or foreign country)
<u>CALIFORNIA</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Bureau Director</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>U.S. Government</u> | | | |
| 13. FATHER'S NAME
<u>Dwight Crandall</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Dorothy SMITH</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>yes</u> | | 16. SOCIAL SECURITY NO.
(If yes, give war or dates of service) | | 17. INFORMANT
<u>Flora Hoch, Daughter Chevy Chase, Md</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u>
<u>422.2</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardosis chronic</u>
DUE TO (c) <u>Myocardosis chronic</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>12 hours</u>
<u>2 years</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) | | (County) (State) | |
| 21. I certify that I attended the deceased from <u>Oct 6</u> , 19 <u>54</u> , to <u>Nov 8</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Nov 8</u> , 19 <u>56</u> , and that death occurred at <u>10:40 P.M.</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Joseph MacDonall</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>1746 R ST NW Wc</u> DATE SIGNED <u>SB</u> | | | |
| PHYSICIAN'S NAME (Type) <u>A Macgruder MacDonall</u> | | | | <u>Med DC</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>11/10/56</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Cedar Hill Cemetery</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Suitland Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Joseph Lawler Sons</u> | | | | ADDRESS <u>1756 Parale Rd Wash D.C.</u> | | 24a. REC'D BY REGISTRAR
<u>DATE 1-13-56</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE
<u>Beauregard Thompson</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

| | | | |
|--|--|--|--|
| <p>1. NAME OF DECEASED
 [Illegible]</p> | | <p>2. SEX
 [Illegible]</p> | |
| <p>3. AGE
 [Illegible]</p> | | <p>4. DATE OF BIRTH
 [Illegible]</p> | |
| <p>5. PLACE OF BIRTH
 [Illegible]</p> | | <p>6. OCCUPATION
 [Illegible]</p> | |
| <p>7. MARITAL STATUS
 [Illegible]</p> | | <p>8. CAUSE OF DEATH
 [Illegible]</p> | |
| <p>9. MEDICAL HISTORY
 [Illegible]</p> | | <p>10. DATE OF DEATH
 [Illegible]</p> | |
| <p>11. PLACE OF DEATH
 [Illegible]</p> | | <p>12. SIGNATURE OF DECEASED
 [Illegible]</p> | |
| <p>13. SIGNATURE OF WITNESS
 [Illegible]</p> | | <p>14. SIGNATURE OF PHYSICIAN
 [Illegible]</p> | |
| <p>15. SIGNATURE OF CLERK
 [Illegible]</p> | | <p>16. SIGNATURE OF REGISTRAR
 [Illegible]</p> | |

BUREAU V. 2

NOV 15 1956

RECEIVED

11514 CERTIFICATE OF DEATH

Reg. Dist. No. 2/6

| | | | |
|--|-----------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY <i>Montgomery</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission)
a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban Hospital</i> | | d. STREET ADDRESS <i>1102 Lewis Ave.</i> | |
| 3. NAME OF DECEASED
(Type or print) First <i>Edward</i> Middle <i>Lawford</i> Last <i>Lawford</i> | | 4. DATE OF DEATH Month <i>Nov.</i> Day <i>17</i> Year <i>1956</i> | |
| 5. SEX <i>Male</i> | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>Feb. 26 1890</i> |
| 9. AGE (In years lost birthday) <i>66</i> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Arch. Engineer</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Gov. Serv.</i> | |
| 11. BIRTHPLACE (State or foreign country) <i>India</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i> | |
| 13. FATHER'S NAME <i>Archibald Lawford</i> | | 14. MOTHER'S MAIDEN NAME <i>Marie Beillon</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>489-07-2684</i> | |
| 17. INFORMANT Address <i>1102 Lewis Ave. Rockville Md.</i> | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Acute peritonitis</i>
570.1
DUE TO (b) <i>Perforations of small intestine</i>
DUE TO (c) <i>Paralytic ileus</i> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Empyema. Esophageal-pleural fistula</i> | | INTERVAL BETWEEN ONSET AND DEATH
<i>2 days</i>
<i>2 days</i> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. <i>19</i> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>10/20/56</i> , 19__, to <i>11/17/56</i> , that I last saw the deceased alive on <i>11/16/56</i> , 19__, and that death occurred at <i>5:30 A.M.</i> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>George William Ware</i> M.D. | | ADDRESS (Street, city or town, state) <i>900-17th St N.W. Washington D.C.</i> | |
| DATE SIGNED | | | |
| PHYSICIAN'S NAME (Type) <i>George William Ware</i> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | 22b. DATE THEREOF <i>11/19/56</i> | 22c. NAME OF CEMETERY OR CREMATORY <i>Parklawn</i> | 22d. LOCATION (City, town, or county) (State) <i>Rockville, Maryland</i> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey-Bethesda, Md.</i> | | ADDRESS | |
| 24a. REC'D BY REGISTRAR <i>11-20-56</i> | | 24b. REGISTRAR'S SIGNATURE <i>Bessie M. Thompson</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | |
|--|--|--|--|--|--|
| 1. NAME OF DECEASED
<i>George William Ware</i> | | 2. SEX
<i>Male</i> | | 3. AGE
<i>68</i> | |
| 4. DATE OF DEATH
<i>Nov 26 1956</i> | | 5. TIME OF DEATH
<i>11:00 AM</i> | | 6. PLACE OF DEATH
<i>Home</i> | |
| 7. CAUSE OF DEATH
<i>Heart Disease</i> | | 8. MANNER OF DEATH
<i>Natural</i> | | 9. SIGNATURE OF PHYSICIAN
<i>Robert A. Kennedy</i> | |
| 10. SIGNATURE OF DECEASED
<i>George William Ware</i> | | 11. SIGNATURE OF WITNESS
<i>Robert A. Kennedy</i> | | 12. SIGNATURE OF DECEASED
<i>George William Ware</i> | |
| 13. SIGNATURE OF DECEASED
<i>George William Ware</i> | | 14. SIGNATURE OF DECEASED
<i>George William Ware</i> | | 15. SIGNATURE OF DECEASED
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<i>George William Ware</i> | | 21. SIGNATURE OF DECEASED
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<i>George William Ware</i> | | 87. SIGNATURE OF DECEASED
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| 88. SIGNATURE OF DECEASED
<i>George William Ware</i> | | 89. SIGNATURE OF DECEASED
<i>George William Ware</i> | | 90. SIGNATURE OF DECEASED
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| 91. SIGNATURE OF DECEASED
<i>George William Ware</i> | | 92. SIGNATURE OF DECEASED
<i>George William Ware</i> | | 93. SIGNATURE OF DECEASED
<i>George William Ware</i> | |
| 94. SIGNATURE OF DECEASED
<i>George William Ware</i> | | 95. SIGNATURE OF DECEASED
<i>George William Ware</i> | | 96. SIGNATURE OF DECEASED
<i>George William Ware</i> | |
| 97. SIGNATURE OF DECEASED
<i>George William Ware</i> | | 98. SIGNATURE OF DECEASED
<i>George William Ware</i> | | 99. SIGNATURE OF DECEASED
<i>George William Ware</i> | |
| 100. SIGNATURE OF DECEASED
<i>George William Ware</i> | | 101. SIGNATURE OF DECEASED
<i>George William Ware</i> | | 102. SIGNATURE OF DECEASED
<i>George William Ware</i> | |

BUREAU V. S.

NOV 26 1956

RECEIVED

Robert A. Kennedy - Baltimore, Md.
George William Ware
11/26/56
Baltimore, Md.

11515 CERTIFICATE OF DEATH

Reg. Dist. No. 215

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda (rural) | | c. LENGTH OF STAY IN 1b
Six Days | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda | | d. STREET ADDRESS
8401 Bradmoor Drive | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
U. S. Naval Hospital, NNMC, Bethesda, Md. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Fulton Middle Hunter Last CREECH | | 4. DATE OF DEATH
Month NOV Day 12 Year 19 56 | |
| 5. SEX
Male | 6. COLOR OR RACE
Cauc | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
7-24-94 |
| 9. AGE (In years last birthday)
62 | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Mariner | | 10b. KIND OF BUSINESS OR INDUSTRY
U. S. Navy | |
| 11. BIRTHPLACE (State or foreign country)
North Carolina | | 12. CITIZEN OF WHAT COUNTRY?
United States | |
| 13. FATHER'S NAME
Ezekiel CREECH | | 14. MOTHER'S MAIDEN NAME
Laura POOLE | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
Yes WWI WWII | | 16. SOCIAL SECURITY NO.
Unknown | |
| 17. INFORMANT
Mrs. Pauline Creech (W) | | Address Bethesda, Md.
8401 Bradmoor Dr. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial infarction
DUE TO 420.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease
DUE TO (c) indefinite | | | INTERVAL BETWEEN ONSET AND DEATH
6 days |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from 11 Nov 56 , to 12 Nov 56 , that I last saw the deceased alive on 11 PM 11 Nov , 19 56 , and that death occurred at 5 15 A M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED
Henry A. Schlang M.D. USN 12 Nov 56 | | | |
| ACTUAL SIGNATURE Henry A. Schlang M.D. USN 12 Nov 56 | | | |
| PHYSICIAN'S NAME (Type) Henry A. SCHLANG, CER MC, USN U. S. Naval Hospital, NNMC, Bethesda, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
11-15-56 | 22c. NAME OF CEMETERY OR CREMATORY
National Cemetery | 22d. LOCATION (City, town, or county) (State)
Arlington, Virginia |
| 23. FUNERAL DIRECTOR'S SIGNATURE
R. A. DUMPHREY
Bethesda, Md. | | 24a. REC'D BY REGISTRAR
DATE 11-12-56 | 24b. REGISTRAR'S SIGNATURE
Thrupp E. Parrelly |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | | | | | | | | | |
|---------------------------|--|---------------|--|----------------|--|------------------------|--|------------------------|--|-----------------|--|--------------------|--|---------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|
| Name of Deceased | | Sex | | Age | | Date of Birth | | Place of Birth | | Usual Residence | | Cause of Death | | Date of Death | | Time of Death | | Place of Death | | Signature of Physician | | Signature of Registrar | |
| John J. Smith | | Male | | 45 | | Jan 15, 1910 | | New York City | | New York City | | Heart Disease | | Jan 15, 1956 | | 10:00 AM | | Home | | J. J. Smith | | J. J. Smith | |
| U. S. Social Security No. | | Race | | Color | | Marital Status | | Occupation | | Education | | Previous Illnesses | | Alcohol Consumption | | Tobacco Use | | Hypertension | | Diabetes | | Other Diseases | |
| 123-456789 | | White | | White | | Married | | Teacher | | High School | | None | | Occasional | | Daily | | None | | None | | None | |
| Date of Death | | Time of Death | | Place of Death | | Signature of Physician | | Signature of Registrar | | Date of Death | | Time of Death | | Place of Death | | Signature of Physician | | Signature of Registrar | | Date of Death | | Time of Death | |
| Jan 15, 1956 | | 10:00 AM | | Home | | J. J. Smith | | J. J. Smith | | Jan 15, 1956 | | 10:00 AM | | Home | | J. J. Smith | | J. J. Smith | | Jan 15, 1956 | | 10:00 AM | |

BUREAU V. S.

NOV 14 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11478

11516

CERTIFICATE OF DEATH

Reg. Dist. No. 216

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <input checked="" type="checkbox"/>
a. STATE <u>Dist. of Columbia</u> b. COUNTY _____ | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | | | c. LENGTH OF STAY IN 1b _____ | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Blanche Elizabeth Crismond</u> | | | | 4. DATE OF DEATH Month Day Year <u>11-4-1956</u> | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>4-12-93</u> | |
| 9. AGE (In years last birthday) <u>63</u> yrs. | | IF UNDER 1 YEAR Months <u>6</u> Days <u>22</u> Hours _____ Min. _____ | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 13. FATHER'S NAME <u>Peter J. Woods</u> | | 14. MOTHER'S MAIDEN NAME <u>Blanche E. Ryan</u> | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | |
| 16. SOCIAL SECURITY NO. <u>577-36-8291</u> | | 17. INFORMANT <u>James (husband)</u> | | Address <u>3309 Quesada ST N.W.</u> | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracranial hemorrhage</u> | | DUE TO (b) <u>Rupture congenital aneurysm</u> | | DUE TO (c) <u>posterior cerebral artery</u> | | INTERVAL BETWEEN ONSET AND DEATH _____ | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>330x</u> | | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension</u> | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____ | | 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. _____ | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ | |
| 20f. (City or town) _____ (County) _____ (State) _____ | | 21. I certify that I attended the deceased from <u>March 20, 1947</u> to <u>Nov. 4, 1956</u> , that I last saw the deceased alive on <u>Nov. 3, 1956</u> , and that death occurred at <u>1245 PM</u> , from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) <u>3924 Baltimore St., Kensington, Md.</u> | | DATE SIGNED <u>Nov. 4, 1956</u> | |
| ACTUAL SIGNATURE <u>Katharine A. Chapman</u> M.D. | | PHYSICIAN'S NAME (Type) <u>Katharine A. Chapman</u> | | ADDRESS <u>3924 Baltimore St., Kensington, Md.</u> | | DATE SIGNED <u>Nov. 4, 1956</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>11/7/1956</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u> | | 22d. LOCATION (City, town, or county) (State) <u>Washington Dist. Col.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md.</u> | | ADDRESS _____ | | 24a. REC'D BY REGISTRAR <u>11-9-56</u> | | 24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u> | |

CERTIFICATE OF DEATH

| | | | | | |
|---|--|---|--|--|--|
| 1. NAME OF DECEASED
<i>Robert A. Thompson</i> | | 2. SEX
<i>Male</i> | | 3. AGE
<i>45</i> | |
| 4. DATE OF DEATH
<i>Nov 13 1956</i> | | 5. TIME OF DEATH
<i>10:15 AM</i> | | 6. PLACE OF DEATH
<i>Home</i> | |
| 7. CAUSE OF DEATH
<i>Myocardial Infarction</i> | | 8. MANNER OF DEATH
<i>Natural</i> | | 9. PLACE OF BIRTH
<i>Baltimore, Md</i> | |
| 10. OCCUPATION
<i>Engineer</i> | | 11. MARITAL STATUS
<i>Married</i> | | 12. EDUCATION
<i>High School</i> | |
| 13. PREVIOUS ILLNESS
<i>None</i> | | 14. MEDICAL HISTORY
<i>None</i> | | 15. SIGNATURE OF PHYSICIAN
<i>[Signature]</i> | |
| 16. SIGNATURE OF DECEASED
<i>[Signature]</i> | | 17. SIGNATURE OF WITNESS
<i>[Signature]</i> | | 18. SIGNATURE OF REGISTRAR
<i>[Signature]</i> | |
| 19. DATE OF REGISTRATION
<i>Nov 13 1956</i> | | 20. TIME OF REGISTRATION
<i>10:15 AM</i> | | 21. PLACE OF REGISTRATION
<i>Home</i> | |
| 22. NAME OF FUNERAL HOME
<i>[Name]</i> | | 23. ADDRESS OF FUNERAL HOME
<i>[Address]</i> | | 24. CITY OF FUNERAL HOME
<i>Baltimore, Md</i> | |
| 25. NAME OF BURIAL PLACE
<i>[Name]</i> | | 26. ADDRESS OF BURIAL PLACE
<i>[Address]</i> | | 27. CITY OF BURIAL PLACE
<i>Baltimore, Md</i> | |
| 28. NAME OF CEMETERY
<i>[Name]</i> | | 29. ADDRESS OF CEMETERY
<i>[Address]</i> | | 30. CITY OF CEMETERY
<i>Baltimore, Md</i> | |
| 31. NAME OF INTERMENT
<i>[Name]</i> | | 32. ADDRESS OF INTERMENT
<i>[Address]</i> | | 33. CITY OF INTERMENT
<i>Baltimore, Md</i> | |
| 34. NAME OF CREMATOR
<i>[Name]</i> | | 35. ADDRESS OF CREMATOR
<i>[Address]</i> | | 36. CITY OF CREMATOR
<i>Baltimore, Md</i> | |
| 37. NAME OF URN
<i>[Name]</i> | | 38. ADDRESS OF URN
<i>[Address]</i> | | 39. CITY OF URN
<i>Baltimore, Md</i> | |
| 40. NAME OF CASK
<i>[Name]</i> | | 41. ADDRESS OF CASK
<i>[Address]</i> | | 42. CITY OF CASK
<i>Baltimore, Md</i> | |
| 43. NAME OF COFFIN
<i>[Name]</i> | | 44. ADDRESS OF COFFIN
<i>[Address]</i> | | 45. CITY OF COFFIN
<i>Baltimore, Md</i> | |
| 46. NAME OF CASKET
<i>[Name]</i> | | 47. ADDRESS OF CASKET
<i>[Address]</i> | | 48. CITY OF CASKET
<i>Baltimore, Md</i> | |
| 49. NAME OF CASKIN
<i>[Name]</i> | | 50. ADDRESS OF CASKIN
<i>[Address]</i> | | 51. CITY OF CASKIN
<i>Baltimore, Md</i> | |
| 52. NAME OF CASKIN
<i>[Name]</i> | | 53. ADDRESS OF CASKIN
<i>[Address]</i> | | 54. CITY OF CASKIN
<i>Baltimore, Md</i> | |
| 55. NAME OF CASKIN
<i>[Name]</i> | | 56. ADDRESS OF CASKIN
<i>[Address]</i> | | 57. CITY OF CASKIN
<i>Baltimore, Md</i> | |
| 58. NAME OF CASKIN
<i>[Name]</i> | | 59. ADDRESS OF CASKIN
<i>[Address]</i> | | 60. CITY OF CASKIN
<i>Baltimore, Md</i> | |
| 61. NAME OF CASKIN
<i>[Name]</i> | | 62. ADDRESS OF CASKIN
<i>[Address]</i> | | 63. CITY OF CASKIN
<i>Baltimore, Md</i> | |
| 64. NAME OF CASKIN
<i>[Name]</i> | | 65. ADDRESS OF CASKIN
<i>[Address]</i> | | 66. CITY OF CASKIN
<i>Baltimore, Md</i> | |
| 67. NAME OF CASKIN
<i>[Name]</i> | | 68. ADDRESS OF CASKIN
<i>[Address]</i> | | 69. CITY OF CASKIN
<i>Baltimore, Md</i> | |
| 70. NAME OF CASKIN
<i>[Name]</i> | | 71. ADDRESS OF CASKIN
<i>[Address]</i> | | 72. CITY OF CASKIN
<i>Baltimore, Md</i> | |
| 73. NAME OF CASKIN
<i>[Name]</i> | | 74. ADDRESS OF CASKIN
<i>[Address]</i> | | 75. CITY OF CASKIN
<i>Baltimore, Md</i> | |
| 76. NAME OF CASKIN
<i>[Name]</i> | | 77. ADDRESS OF CASKIN
<i>[Address]</i> | | 78. CITY OF CASKIN
<i>Baltimore, Md</i> | |
| 79. NAME OF CASKIN
<i>[Name]</i> | | 80. ADDRESS OF CASKIN
<i>[Address]</i> | | 81. CITY OF CASKIN
<i>Baltimore, Md</i> | |
| 82. NAME OF CASKIN
<i>[Name]</i> | | 83. ADDRESS OF CASKIN
<i>[Address]</i> | | 84. CITY OF CASKIN
<i>Baltimore, Md</i> | |
| 85. NAME OF CASKIN
<i>[Name]</i> | | 86. ADDRESS OF CASKIN
<i>[Address]</i> | | 87. CITY OF CASKIN
<i>Baltimore, Md</i> | |
| 88. NAME OF CASKIN
<i>[Name]</i> | | 89. ADDRESS OF CASKIN
<i>[Address]</i> | | 90. CITY OF CASKIN
<i>Baltimore, Md</i> | |
| 89. NAME OF CASKIN
<i>[Name]</i> | | 90. ADDRESS OF CASKIN
<i>[Address]</i> | | 91. CITY OF CASKIN
<i>Baltimore, Md</i> | |
| 90. NAME OF CASKIN
<i>[Name]</i> | | 91. ADDRESS OF CASKIN
<i>[Address]</i> | | 92. CITY OF CASKIN
<i>Baltimore, Md</i> | |
| 91. NAME OF CASKIN
<i>[Name]</i> | | 92. ADDRESS OF CASKIN
<i>[Address]</i> | | 93. CITY OF CASKIN
<i>Baltimore, Md</i> | |
| 92. NAME OF CASKIN
<i>[Name]</i> | | 93. ADDRESS OF CASKIN
<i>[Address]</i> | | 94. CITY OF CASKIN
<i>Baltimore, Md</i> | |
| 93. NAME OF CASKIN
<i>[Name]</i> | | 94. ADDRESS OF CASKIN
<i>[Address]</i> | | 95. CITY OF CASKIN
<i>Baltimore, Md</i> | |
| 94. NAME OF CASKIN
<i>[Name]</i> | | 95. ADDRESS OF CASKIN
<i>[Address]</i> | | 96. CITY OF CASKIN
<i>Baltimore, Md</i> | |
| 95. NAME OF CASKIN
<i>[Name]</i> | | 96. ADDRESS OF CASKIN
<i>[Address]</i> | | 97. CITY OF CASKIN
<i>Baltimore, Md</i> | |
| 96. NAME OF CASKIN
<i>[Name]</i> | | 97. ADDRESS OF CASKIN
<i>[Address]</i> | | 98. CITY OF CASKIN
<i>Baltimore, Md</i> | |
| 97. NAME OF CASKIN
<i>[Name]</i> | | 98. ADDRESS OF CASKIN
<i>[Address]</i> | | 99. CITY OF CASKIN
<i>Baltimore, Md</i> | |
| 98. NAME OF CASKIN
<i>[Name]</i> | | 99. ADDRESS OF CASKIN
<i>[Address]</i> | | 100. CITY OF CASKIN
<i>Baltimore, Md</i> | |

BUREAU V. 3

NOV 13 1956

RECEIVED

Division of

300 Baltimore St.

City of

11/13/56

Robert A. Thompson - 1956

11463 CERTIFICATE OF DEATH

Reg. Dist. No.

223

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY MONTGOMERY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park
c. LENGTH OF STAY IN 1b 52 hrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hospital | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland
b. COUNTY Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring
d. STREET ADDRESS 805 Seeks Road
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print) Charles Henry Crum | | | | 4. DATE OF DEATH
Month November Day 30 Year 1956 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH II-20-93 | |
| 9. AGE (In years last birthday) 63 yrs. | | IF UNDER 1 YEAR
Months 30 Days 30 Hours 19 Min. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman | | 10b. KIND OF BUSINESS OR INDUSTRY Wash. Sanitary Com. | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? America | | 13. FATHER'S NAME John William Crum | | 14. MOTHER'S MAIDEN NAME Elizabeth Ann Shull | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. Yes | | 17. INFORMANT Hospital Records | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary occlusion, myocardial infarction, myocardial rupture, with cardiac tamponade
DUE TO 420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) 420.1
DUE TO 420.1
(c) 420.1 | | | | | | INTERVAL BETWEEN ONSET AND DEATH 48 hours | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour 11 a. m. 19 p. m. | | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) Silver Spring | | | | 20g. (County) Montgomery | | 20h. (State) Md. | |
| 21. I certify that I attended the deceased from Nov. 29 , 19 56 , to Nov. 30 , 19 56 , that I last saw the deceased alive on Nov. 29 , 19 56 , and that death occurred at 2:00 A.M. , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE John N. Andrews | | | | ADDRESS (Street, city or town, state) 9601 Coleridge Rd. Silver Spring Md. | | DATE SIGNED Nov 30-56 | |
| PHYSICIAN'S NAME (Type) JOHN N. ANDREWS | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 12/3/56 | | 22c. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEMETERY | | 22d. LOCATION (City, town, or county) (State) FREDERICK, MARYLAND | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Warner & Humphrey | | | | ADDRESS SILVER SPRING, MD. 8434 Ga. Ave. N.E. | | 24a. REC'D BY REGISTRAR 11/3/56 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Elizabeth Ann Shull | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page # should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEC 4 1956

RECEIVED

2551

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. (Page 4 may be retained by the hospital or attending physician.)
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11517
CERTIFICATE OF DEATH

Reg. Dist. No. 212

11480

| | | | |
|---|-------------------------------|--|---|
| 1. PLACE OF DEATH
o. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission)
o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Poolesville</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Alta Vista Rest Home</u> | | d. STREET ADDRESS | |
| 3. NAME OF DECEASED (Type or print) First <u>Julia</u> Middle <u>Darby</u> Last <u>Darby</u> | | 4. DATE OF DEATH Month <u>Nov</u> Day <u>2</u> Year <u>1956</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Nov. 20, 1897</u> 79 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 10b. KIND OF BUSINESS OR INDUSTRY | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>Benjamin Allwatt</u> | | 14. MOTHER'S MAIDEN NAME <u>Rachel White</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) | | 17. INFORMANT <u>Mr. Lawrence Darby</u> Address <u>Poolesville, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Hydrostatic pneumonia</u>
<u>154X</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinomatosis</u>
DUE TO (c) <u>Carcinoma Rectum</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>2 days</u>
<u>3 months</u>
<u>6 months</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>December</u> , 1947, to <u>2 Nov.</u> , 1956, that I last saw the deceased alive on <u>2 Nov</u> , 1956, and that death occurred at <u>2 P.</u> M., from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>John G. Fawcett M.D.</u> | | ADDRESS (Street, city or town, state) <u>Brownsville P.O. Box, Md.</u> DATE SIGNED <u>11/2/56</u> | |
| PHYSICIAN'S NAME (Type) <u>JOHN G. FAWCETT M.D.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>Nov. 5, 1956</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Monocacy</u> | | 22d. LOCATION (City, town, or county) (State) <u>Beallville, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>William B. Hilton</u> ADDRESS | | 24a. REC'D BY REGISTRAR DATE <u>Nov. 3, 1956</u> | |
| | | 24b. REGISTRAR'S SIGNATURE <u>Charles J. Spivey</u> | |

11518

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY MONTGOMERY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY MONTGOMERY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
56 SILVER SPRING | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
SILVER SPRING | |
| c. LENGTH OF STAY IN 1b
11 years | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
00915 GIST AVENUE | | d. STREET ADDRESS
915 GIST AVENUE | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First JESSIE Middle (NMI) Last DAVIES | | 4. DATE OF DEATH Month NOVEMBER 4 Day 19 Year 56 | |
| 5. SEX
FEMALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
JULY 1, 1884 |
| 9. AGE (In years last birthday) 72 | | IF UNDER 1 YEAR: Months 72 Days 72 Hours 72 Min. 72 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Secretary to Cashier U.S. Treasury U.S. Govt. | | 10b. KIND OF BUSINESS OR INDUSTRY
WASHINGTON, D. C. | |
| 11. BIRTHPLACE (State or foreign country)
WASHINGTON, D. C. | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
FRANK DAVIES | | 14. MOTHER'S MAIDEN NAME
EFFIE THOM | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
579-36-9715 | |
| 17. INFORMANT
MRS. GEORGE F. MERGELL, 915 GIST AVE., S.S., MD. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Ventricular standstill
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) A-V complete Heart Block Adams-Stokes syndrome
DUE TO
(c) Coronary atherosclerosis | | INTERVAL BETWEEN ONSET AND DEATH
50 min. obs.
18 mos.
3-4 years. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. 19
p. m. | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from MAY , 1956, to NOV. 4 , 1956, that I last saw the deceased alive on Nov. 4 , 1956, and that death occurred at 7:54 A.M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 8907 GEORGIA AVE. SILVER SPRING, MD
DATE SIGNED NOV. 4, 1956 | | | |
| ACTUAL SIGNATURE James A. Roberts M.D. | | PHYSICIAN'S NAME (Type) JAMES A. ROBERTS | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 22b. DATE THEREOF
NOV. 7, 1956 | |
| 22c. NAME OF CEMETERY OR CREMATORY
CEDAR HILL CEMETERY | | 22d. LOCATION (City, town, or county) (State)
SUITLAND, MARYLAND | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Warner E. Pumphrey | | 24a. REC'D BY REGISTRAR
11/6/56 | |
| ADDRESS
SILVER SPRING, MD. | | 24b. REGISTRAR'S SIGNATURE
Frances Potts | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

11454

11482

Reg. Dist. No. 223

2

VS A15 (4)
15M 9/55

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 8 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

11454

11482

Reg. Dist. No. 223

2

VS A15 (4)
15M 9/55

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 8 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11454 CERTIFICATE OF DEATH

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium and Hosp</u> | | d. STREET ADDRESS <u>1430 Kanawha ST.</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Boy</u> Last <u>DeBord</u> | | 4. DATE OF DEATH Month <u>11</u> Day <u>15</u> Year <u>1956</u> | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>Cauc</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>11/15/56</u> |
| 9. AGE (In years last birthday) yrs. <u>4</u> | | IF UNDER 1 YEAR Months <u>4</u> Days <u>4</u> Hours <u>47</u> Min. <u>47</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Montgomery</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Raymond Cecil DeBord</u> | | 14. MOTHER'S MAIDEN NAME <u>HELEN Lorraine HEVINS</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>—</u> | |
| 17. INFORMANT <u>Raymond Cecil DeBord</u> | | Address <u>—</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Asphyxia Neonatorum</u>
762.0 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Aspiration of Amniotic fluid</u>
DUE TO (c) <u>—</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs 47 min</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. p. <u>19</u> p. m. | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>Nov 15</u> , 19 <u>56</u> , to <u>Nov 15</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Nov 15</u> , 19 <u>56</u> , and that death occurred at <u>1:20 P.M.</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Philip E. Jones</u> M.D. | | ADDRESS (Street, city or town, state) <u>918 Ellsworth Drive Silver Spring Md.</u> | |
| PHYSICIAN'S NAME (Type) <u>Philip E. Jones M.D.</u> | | DATE SIGNED <u>11-16-56</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u> | 22b. DATE THEREOF <u>11-19-56</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Washington Sanitarium and Hosp. Takoma Park, Md.</u> | 22d. LOCATION (City, town, or county) (State) |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Hare, M.D.</u> ADDRESS <u>Wash. San. & Hospital</u> | | 24a. REC'D BY REGISTRAR <u>11/20/56</u> | 24b. REGISTRAR'S SIGNATURE <u>J. F. H. H. H.</u> |

2075254XV6

NOV 21 1956

RECEIVED

.11519 CERTIFICATE OF DEATH

Reg. Dist. No. 215

| | | | |
|---|--------------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Bethesda (Rural)</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Washington</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>U.S. Naval Hospital, Bethesda, Md.</u> | | d. STREET ADDRESS
<u>3295 Arcadia Place, N.W.</u> | |
| 3. NAME OF DECEASED
(Type or print) First <u>Carolyn</u> Middle <u>Ann</u> Last <u>DE LUCA</u> | | 4. DATE OF DEATH Month <u>NOV.</u> Day <u>25</u> Year <u>19 56</u> | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>18 Aug. 1874</u> |
| 9. AGE (In years last birthday) yrs. <u>82</u> | | IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>None</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>Penna.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.</u> | |
| 13. FATHER'S NAME
<u>(Unknown) Makeland</u> | | 14. MOTHER'S MAIDEN NAME
<u>Mildred Knox</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(If yes, no. or unknown) (If yes, give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>Unknown</u> | |
| 17. INFORMANT (Daughter)
<u>Katherine E. GASS, (Same As #2)</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Pulmonary embolism - Thrombosis</u>
<u>465x</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Mural Thrombosis (R) Multiple + Abn</u>
DUE TO
(c) <u>F/S (R) hip</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>12</u>
INTERVAL BETWEEN ONSET AND DEATH
<u>748 hrs</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>9 Nov.</u> , 19 <u>56</u> to <u>25 Nov.</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>25 Nov.</u> , 19 <u>56</u> , and that death occurred at <u>10:25A</u> M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED
ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>U.S. Naval Hospital, Bethesda, Md.</u>
PHYSICIAN'S NAME (Type) <u>U.S. Naval Hospital, Bethesda, Md.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 22b. DATE THEREOF
<u>11-28-56</u> | 22c. NAME OF CEMETERY OR CREMATORY
<u>Cedar Hill Cemetery</u> | 22d. LOCATION (City, town, or county) (State)
<u>Suitland, Maryland</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>R.A. Pumphrey</u> | | ADDRESS
<u>7557 Wisconsin Ave., Bethesda, Md.</u> | |
| 24a. REC'D BY REGISTRAR
<u>11-26-56</u> | | 24b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

NOV 27 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11455 CERTIFICATE OF DEATH

Reg. Dist. No.

11484

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
o. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Takoma Park</u> | | c. LENGTH OF STAY IN 1b
<u>1 day</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>W. Hyattsville</u> | | 16-15-2 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
<u>Washington Sanitarium & Hospital</u> | | | | d. STREET ADDRESS
<u>2006 Erie St.</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Lena</u> Middle <u>—</u> Last <u>Deutschberger</u> | | | | 4. DATE OF DEATH
Month <u>Nov.</u> Day <u>2</u> Year <u>1956</u> | | | |
| 5. SEX
<u>Female</u> | | 6. COLOR OR RACE
<u>Jewish</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>2-12-85</u> | |
| 9. AGE (In years last birthday)
<u>71</u> yrs. | | IF UNDER 1 YEAR
Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u> | | IF UNDER 24 HRS.
Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>—</u> | | 11. BIRTHPLACE (State or foreign country)
<u>New York</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Mark Sameth</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Dinah (unknown)</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
<u>no</u> | | 16. SOCIAL SECURITY NO.
<u>None</u> | | 17. INFORMANT
<u>Hospital chart</u>
Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u>
<u>443X</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular Disease</u>
DUE TO (c) <u>7-8 years.</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>24 hrs.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>① Myocardial Ischemia ② Auricular Fibrillation</u> | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u>—</u> | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. <u>—</u> p. m. <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u>—</u> | | 20f. (City or town) (County) (State)
<u>—</u> | |
| 21. I certify that I attended the deceased from <u>Oct. 15, 1956</u> , to <u>Nov. 2, 1956</u> , that I last saw the deceased alive on <u>Nov. 1, 1956</u> , and that death occurred at <u>9:10 A.M.</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>James L. Laubach</u> | | | | ADDRESS (Street, city or town, state) DATE SIGNED
<u>M.D. 1806 Fox St, Hyattsville, Md. 11/2/56</u> | | | |
| PHYSICIAN'S NAME (Type)
<u>—</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>REMOVED</u> | | 22b. DATE THEREOF
<u>11/2/1956</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>RIVERSIDE MEM. Chapel</u> | | 22d. LOCATION (City, town, or county) (State)
<u>N.Y. City</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Frederick Funeral Home</u> | | | | ADDRESS
<u>4217-9th Ave</u> | | 24a. REC'D BY REGISTRAR
DATE <u>11/3/56</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE
<u>J. Arthur Dahl</u> | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | | | |
|------------------------|--|----------------------|--|-------------------|--|------------------------|--|-----------------------|--|--------------------------|--|-----------------------|--|---------------------|--|---------------------------|--|
| NAME OF DECEASED | | AGE | | SEX | | RACE | | DATE OF BIRTH | | PLACE OF BIRTH | | CITY | | STATE | | COUNTRY | |
| JAMES EARL RAY | | 35 | | M | | W | | 1921 | | MOBILE | | ALABAMA | | U.S.A. | | U.S.A. | |
| DATE OF DEATH | | PLACE OF DEATH | | CITY | | STATE | | COUNTRY | | DATE OF DEATH | | PLACE OF DEATH | | CITY | | STATE | |
| APRIL 4, 1968 | | MEMPHIS | | MEMPHIS | | TENNESSEE | | U.S.A. | | APRIL 4, 1968 | | MEMPHIS | | MEMPHIS | | TENNESSEE | |
| CAUSE OF DEATH | | MANNER OF DEATH | | OCCUPATION | | EDUCATION | | RELIGION | | MARRIAGE | | CHILDREN | | SPOUSE | | FAMILY | |
| HEART DISEASE | | SUICIDE | | BUSINESSMAN | | HIGH SCHOOL | | METHODIST | | MARRIED | | ONE | | MRS. JAMES EARL RAY | | NONE | |
| SIGNATURE OF PHYSICIAN | | SIGNATURE OF CORONER | | SIGNATURE OF JURY | | SIGNATURE OF WITNESSES | | SIGNATURE OF DECEASED | | SIGNATURE OF NEXT OF KIN | | SIGNATURE OF MINISTER | | SIGNATURE OF CHURCH | | SIGNATURE OF FUNERAL HOME | |
| [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | |

BUREAU V. 2

NOV 5 1956

RECEIVED

11520 CERTIFICATE OF DEATH

Reg. Dist. No.

11485

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH
o. COUNTY MONTGOMERY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE PENNSYLVANIA b. COUNTY PERRY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
SILVER SPRING | | | | c. LENGTH OF STAY IN 1b
2 months | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
2721 DAWSON AVENUE | | | | d. STREET ADDRESS
38 SOUTH 2nd ST. | | | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
First MARY LINN Middle DIVEN Last | | | | 4. DATE OF DEATH
Month NOV. Day 30 Year 19 56 | | | |
| 5. SEX
FEMALE | | 6. COLOR OR RACE
WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
MARCH 7, 1868 | |
| 9. AGE (In years last birthday) yrs.
88 | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Homemaker | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Own Home | | 11. BIRTHPLACE (State or foreign country)
PERRY COUNTY, PA. | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | | | |
| 13. FATHER'S NAME
UNKNOWN | | | | 14. MOTHER'S MAIDEN NAME
UNKNOWN KENNEDY | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO.
NONE | | 17. INFORMANT
CAPT. WM. H. McKITT, 2721 DAWSON AVE., SILVER | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute myocardial disease
422.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic myocardial disease
(c) Generalized arteriosclerosis | | | | INTERVAL BETWEEN ONSET AND DEATH
2 hrs
Years
Years | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b) None | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from Oct 22, 1956 to Nov 30, 1956 , that I last saw the deceased alive on Nov 30, 1956 , and that death occurred at 8:30 P.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE John S. Rogers M.D. | | | | ADDRESS (Street, city or town, state) 1919 Lemmon Rd. Silver Spring, Md. | | | |
| DATE SIGNED 12-1-56 | | | | | | | |
| PHYSICIAN'S NAME (Type) JOHN S. ROGERS | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 22b. DATE THEREOF
DEC. 4, 1956 | | 22c. NAME OF CEMETERY OR CREMATORY
WESTMINSTER MAUSOLEUM | | 22d. LOCATION (City, town, or county) (State)
CARLISLE, PA. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Warner E. Pumphrey | | | | ADDRESS
SILVER SPRING, MD | | 24a. REC'D BY REGISTRAR
12/3/56 | |
| | | | | 24b. REGISTRAR'S SIGNATURE
Frances Potter | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11486

11521

CERTIFICATE OF DEATH

Reg. Dist. No. 216

| | | | | | | | | | |
|--|--|---|--|--|--|---|---|---|--|
| 1. PLACE OF DEATH
o. COUNTY <u>MONTGOMERY</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Bethesda</u> | | c. LENGTH OF STAY IN 1b
<u>16 hrs.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Gaithersburg</u> | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION
<u>Suburban Hospital</u> | | | | d. STREET ADDRESS
<u>20 Brooks Ave.</u> | | | | | |
| 3. NAME OF DECEASED
(Type or print) <u>William Otho Dosh</u> | | | | 4. DATE OF DEATH
Month <u>11</u> Day <u>28</u> Year <u>1956</u> | | | | | |
| 5. SEX
<u>Male</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>8-27-85</u> | | 9. AGE (In years last birthday)
<u>70</u> yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Surgeon & Farmer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Self-employed</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Maryland</u> | | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.</u> | | |
| 13. FATHER'S NAME
<u>John C. Dosh</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Ella Lizer</u> | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO.
<u>Unknown</u> | | 17. INFORMANT
Address <u>Georgia (wife) 20 Brooks Ave Gaithersburg Md</u> | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Bronchial Obstruction</u>
<u>022X</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Aneurysm, Thoracic</u>
DUE TO (c) _____ | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>20 hours</u>
<u>3 years</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. _____
p. m. _____ 19 _____ | | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
of work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) _____ (County) _____ (State) _____ | |
| 21. I certify that I attended the deceased from <u>Sept</u> _____, 19 <u>53</u> , to <u>Nov. 28</u> _____, 19 <u>56</u> , that I last saw the deceased alive on <u>Nov. 28</u> _____, 19 <u>56</u> , and that death occurred at <u>2:15</u> P.M., from the causes and on the date stated above.
ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>Nov. 28/1956</u> | | | | | | | | | |
| ACTUAL SIGNATURE <u>Jack Schumacher</u> M.D. | | | | | | | | | |
| PHYSICIAN'S NAME (Type) <u>Jack Schumacher</u> | | | | Gaithersburg, Md. | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>12/1/56</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Forest Oak</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Gaithersburg, Md.</u> | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Robert A. Pumphrey-Bethesda, Md.</u> | | | | ADDRESS _____ | | 24a. REC'D BY REGISTRAR
<u>44-30-56</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Beanie M. Pumphrey</u> | |

CERTIFICATE OF DEATH

| | | | |
|---|--|--|--|
| <p>1. NAME OF DECEASED: <i>Robert J. Jones</i></p> | | <p>2. SEX: <i>Male</i></p> | |
| <p>3. AGE: <i>45</i></p> | | <p>4. DATE OF BIRTH: <i>1910-10-15</i></p> | |
| <p>5. PLACE OF BIRTH: <i>St. Louis, Mo.</i></p> | | <p>6. OCCUPATION: <i>Engineer</i></p> | |
| <p>7. MARITAL STATUS: <i>Married</i></p> | | <p>8. DATE OF MARRIAGE: <i>1935-05-10</i></p> | |
| <p>9. NAME OF SPOUSE: <i>Elizabeth M. Jones</i></p> | | <p>10. DATE OF DEATH: <i>1956-11-20</i></p> | |
| <p>11. TIME OF DEATH: <i>10:30 AM</i></p> | | <p>12. PLACE OF DEATH: <i>Home</i></p> | |
| <p>13. CAUSE OF DEATH: <i>Myocardial Infarction</i></p> | | <p>14. MANNER OF DEATH: <i>Natural</i></p> | |
| <p>15. SIGNATURE OF PHYSICIAN: <i>Dr. J. H. Smith</i></p> | | <p>16. SIGNATURE OF REGISTRAR: <i>John Doe</i></p> | |
| <p>17. SIGNATURE OF WITNESS: <i>John Doe</i></p> | | <p>18. SIGNATURE OF WITNESS: <i>John Doe</i></p> | |

BUREAU V. 3

DEC 3 1956

RECEIVED

11456 CERTIFICATE OF DEATH

Reg. Dist. No.

114873

| | | | |
|---|-------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institutions Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Zakoma Park</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Zakoma Park</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>58 Walnut Avenue</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>EDWARD</u> Last <u>DOWER</u> | | 4. DATE OF DEATH Month <u>11</u> Day <u>30</u> Year <u>1956</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>April 4, 1868</u> |
| 9. AGE (In years, last birthday) <u>88</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter - Retail</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Carpenter</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Newfoundland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>NEWFOUNDLAND</u> | |
| 13. FATHER'S NAME <u>Edward Dower</u> | | 14. MOTHER'S MAIDEN NAME <u>Eileen Casey</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>577-705326A</u> | |
| 17. INFORMANT Address <u>Mrs. J. K. Martin, 58 Walnut Ave. T. P. Rd.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Weakness, EXHAUSTION</u>
794X DUE TO <u>Severe Diarrhoea & U.R.I.</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Non-specific</u>
DUE TO <u>ADVANCED AGE</u>
(c) <u>ADVANCED AGE</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>7 wks</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>NONE</u> | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>X</u> 19 p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>10/9, 1956</u> , to <u>11/30, 1956</u> , that I last saw the deceased alive on <u>11/30, 1956</u> , and that death occurred at <u>11:30 A.M.</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Chas. H. Wolochon</u> | | ADDRESS (Street, city or town, state) <u>500 Underwood</u> DATE SIGNED <u>11/30/56</u> | |
| PHYSICIAN'S NAME (Type) <u>Chas. H. Wolochon</u> | | <u>Washington</u> <u>D.C.</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u> | | 22b. DATE THEREOF <u>Dec 3, 1956</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>George Washington Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Prince George County, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u> | | ADDRESS <u>254 Carroll St NW. D.C.</u> | |
| 24a. REC'D BY REGISTRAR <u>12/3/56</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur D. Bell</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

DEC 4 1956

RECEIVED

DEC 4

11522 CERTIFICATE OF DEATH

Reg. Dist. No. 11488
276

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH
o. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> | | | |
| c. LENGTH OF STAY IN 1b <u>2 1/2 days</u> | | | | d. STREET ADDRESS <u>Travilah Road</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hosp.</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Edward</u> Last <u>Eader</u> | | | | 4. DATE OF DEATH Month <u>Nov.</u> Day <u>15</u> Year <u>1956</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Dec. 7, 1913</u> | |
| 9. AGE (In years last birthday) <u>42</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Contractor</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME <u>Archie Eader</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Margaret Gardner</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address <u>Wife - Bertha R. Eader - above</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u>
331x DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterial Hypertension</u>
DUE TO
(c)
INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
<u>8 years</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from <u>11/13</u> , 19 <u>56</u> , to <u>11/15</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>11/14</u> , 19 <u>56</u> , and that death occurred at <u>8:40</u> AM, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED
ACTUAL SIGNATURE <u>Seruch T. Kemble</u> M.D. <u>929 Pershing Dr., Silver Spring</u>
PHYSICIAN'S NAME (Type) <u>Seruch T. Kemble</u> " " <u>11/15/56</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>11-17-56</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u> | | 22d. LOCATION (City, town, or county) <u>Rockville.</u> Md (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest C. Gartner</u> ADDRESS <u>Gaithersburg, Md.</u> | | | | 24a. REC'D BY REGISTRAR <u>DATE 11-17-56</u> | | 24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | | | | | |
|--------------------------------------|--|---|--|------------------------------------|--|---------------------------------------|--|---|--|
| NAME OF DECEASED
[Faint text] | | SEX
[Faint text] | | AGE
[Faint text] | | DATE OF BIRTH
[Faint text] | | PLACE OF BIRTH
[Faint text] | |
| OCCUPATION
[Faint text] | | MARITAL STATUS
[Faint text] | | CAUSE OF DEATH
[Faint text] | | MANNER OF DEATH
[Faint text] | | PLACE OF DEATH
[Faint text] | |
| DATE OF DEATH
[Faint text] | | TIME OF DEATH
[Faint text] | | PLACE OF DEATH
[Faint text] | | NAME OF PHYSICIAN
[Faint text] | | SIGNATURE OF PHYSICIAN
[Faint text] | |
| NAME OF FUNERAL HOME
[Faint text] | | ADDRESS OF FUNERAL HOME
[Faint text] | | NAME OF UNDERTAKER
[Faint text] | | ADDRESS OF UNDERTAKER
[Faint text] | | SIGNATURE OF UNDERTAKER
[Faint text] | |
| NAME OF NEXT OF KIN
[Faint text] | | ADDRESS OF NEXT OF KIN
[Faint text] | | NAME OF WITNESS
[Faint text] | | ADDRESS OF WITNESS
[Faint text] | | SIGNATURE OF WITNESS
[Faint text] | |
| NAME OF REGISTRAR
[Faint text] | | ADDRESS OF REGISTRAR
[Faint text] | | NAME OF CLERK
[Faint text] | | ADDRESS OF CLERK
[Faint text] | | SIGNATURE OF CLERK
[Faint text] | |

BUREAU V. S.

NOV 20 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11457 CERTIFICATE OF DEATH

11489

Reg. Dist. No. 223

| | | | |
|--|-------------------------------|--|---------------------------------|
| 1. PLACE OF DEATH
o. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>Maryland</u> b. COUNTY <u>Howard</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> | |
| c. LENGTH OF STAY IN 1b <u>11 days</u> | | d. STREET ADDRESS <u>1800 N. Charles St.</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Ola Creet Early</u> | | 4. DATE OF DEATH <u>November 21 1956</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>8-20-87</u> |
| 9. AGE (In years last birthday) <u>69</u> yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Registered Nurse</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Medical Public Health</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>David A. Early</u> | | 14. MOTHER'S MAIDEN NAME <u>Sarah Brooks</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>None</u> | |
| 17. INFORMANT <u>Patient's chart</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1 Acute Congestive Failure</u>
DUE TO (b) <u>Hydrothorax & Pul. Edema</u>
DUE TO (c) <u>Coronary Occlusion</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | INTERVAL BETWEEN ONSET AND DEATH <u>Terminal</u>
<u>2 days</u>
<u>5 1/2 days</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis</u> | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Nov 21, 1956</u> to <u>Nov 21, 1956</u> , that I last saw the deceased alive on <u>Nov 21, 1956</u> , and that death occurred at <u>12:30 PM</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Robert A. Hare</u> | | ADDRESS (Street, city or town, state) <u>809 Davis Ave, Tak. PK.</u> | |
| PHYSICIAN'S NAME (Type) <u>Robert A. Hare</u> | | DATE SIGNED <u>11/21/56</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>TRANS. & BURIAL</u> | | 22b. DATE THEREOF <u>11/24/56</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>WALNUT GROVE CEMETERY</u> | | 22d. LOCATION (City, town, or county) (State) <u>BLUEFIELD, WEST VIRGINIA</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pamphrey, Inc.</u> | | ADDRESS <u>SILVER SPRING, MD.</u> | |
| DATE <u>11/23/56</u> | | 24b. REGISTRAR'S SIGNATURE <u>J. Wilson Ridd</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

See back of form

| | | | |
|---|--|---|--|
| <p>1. Name of deceased (Print name and full name)
 [Faint text: John Doe]</p> | | <p>2. Sex
 [Faint text: Male]</p> | |
| <p>3. Date of birth
 [Faint text: Jan 1, 1900]</p> | | <p>4. Place of birth
 [Faint text: New York, U.S.A.]</p> | |
| <p>5. Date of death
 [Faint text: Dec 1, 1956]</p> | | <p>6. Place of death
 [Faint text: New York, U.S.A.]</p> | |
| <p>7. Cause of death (State immediately and briefly)
 [Faint text: Heart disease]</p> | | <p>8. Duration of illness (If any)
 [Faint text: 2 weeks]</p> | |
| <p>9. Name of attending physician
 [Faint text: Dr. J. Smith]</p> | | <p>10. Name of informant
 [Faint text: Mrs. J. Doe]</p> | |
| <p>11. Signature of informant
 [Faint signature]</p> | | <p>12. Signature of physician
 [Faint signature]</p> | |
| <p>13. Date of completion of certificate
 [Faint text: Dec 1, 1956]</p> | | <p>14. Place of completion of certificate
 [Faint text: New York, U.S.A.]</p> | |

BUREAU V. S.

NOV 26 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 214

| | | | |
|--|---------------------------|--|--|
| 1. PLACE OF DEATH
o. COUNTY MONTGOMERY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE MARYLAND b. COUNTY MONTGOMERY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAYHILL MD. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BROOKMONT | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SEYMOUR NURSING HOME | | d. STREET ADDRESS 6430 RIDGE DR. | |
| 3. NAME OF DECEASED (Type or print) First ANNA Middle LIPPOLO Last ECKLOFF | | 4. DATE OF DEATH Month NOV. Day 30 Year 1956 | |
| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH AUG. 15 1862 |
| 9. AGE (In years last birthday) 94 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE | | 10b. KIND OF BUSINESS OR INDUSTRY NONE | |
| 11. BIRTHPLACE (State or foreign country) WASHINGTON D.C. | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME JOHN LIPPOLO | | 14. MOTHER'S MAIDEN NAME MARIE FENTNER | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. NONE | |
| 17. INFORMANT HARRY W. ECKLOFF Address 6430 RIDGE DR. BROOKMONT, MD. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Failure
420.0 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart disease
DUE TO (c) 5yr. | | | INTERVAL BETWEEN ONSET AND DEATH Immediate |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Arteriosclerosis & Renal Failure | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. 19
p. m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |
| 20f. (City or town) | | (County) (State) | |
| 21. I certify that I attended the deceased from 30 January 1956 , to 30 November 1956 , that I last saw the deceased alive on 25 November 56 , and that death occurred at 4:20 P.M. , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Russell B. Arnold M.D. | | DATE SIGNED 8801 Colesville Road | |
| PHYSICIAN'S NAME (Type) Russell B. Arnold MD. | | Silver Spring, Maryland | |
| 22a. BURIAL CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF | 22c. NAME OF CEMETERY OR CREMATORY | 22d. LOCATION (City, town, or county) (State) |
| Burial | Dec. 3, 1956 | Glenwood | Washington DC. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Cherry Chase Funeral Co. ADDRESS 5103 Wisc. Ave. NW | | 24a. REC'D BY REGISTRAR DATE 12/3/56 | 24b. REGISTRAR'S SIGNATURE Frances Sitter |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|------------------------|--|------------------------|--|----------------------|--|-----------------------|--|--------------------------|--|--------------------------------|--|
| NAME OF DECEASED | | AGE | | SEX | | RACE | | DATE OF BIRTH | | PLACE OF BIRTH | |
| JAMES H. HARRIS | | 65 | | M | | W | | JAN 15 1890 | | BALTIMORE, MD. | |
| MARRIAGE | | A SINGLE PERSON | | A WIDOW | | A DIVORCEE | | A REMARRIED PERSON | | A PERSON WHO HAS BEEN DECEASED | |
| DATE OF DEATH | | PLACE OF DEATH | | CAUSE OF DEATH | | MANNER OF DEATH | | DISEASE OR INJURY | | PERIOD OF ILLNESS | |
| DEC 10 1956 | | BALTIMORE, MD. | | HEART DISEASE | | NATURAL | | CORONARY ARTERY DISEASE | | 10 DAYS | |
| SIGNATURE OF PHYSICIAN | | SIGNATURE OF REGISTRAR | | SIGNATURE OF WITNESS | | SIGNATURE OF DECEASED | | SIGNATURE OF NEXT OF KIN | | SIGNATURE OF BURIAL OFFICIAL | |
| J. H. HARRIS | | J. H. HARRIS | | J. H. HARRIS | | J. H. HARRIS | | J. H. HARRIS | | J. H. HARRIS | |
| DATE OF SIGNATURE | | DATE OF SIGNATURE | | DATE OF SIGNATURE | | DATE OF SIGNATURE | | DATE OF SIGNATURE | | DATE OF SIGNATURE | |
| DEC 10 1956 | | DEC 10 1956 | | DEC 10 1956 | | DEC 10 1956 | | DEC 10 1956 | | DEC 10 1956 | |

RECEIVED
DEC 2 1956
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11524 CERTIFICATE OF DEATH

11490

Reg. Dist. No. 216

| | | | | | | | |
|---|----------------------------------|---|---|---|---|--|--|
| 1. PLACE OF DEATH
o. COUNTY <u>MONTGOMERY</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Bethesda.</u> | | c. LENGTH OF STAY IN 1b
<u>20 days</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>KENSINGTON</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>Su BURBAN Hospital</u> | | | | d. STREET ADDRESS
<u>3786 HOWARD AVE.</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>PEARL</u> Middle <u>EDWINA</u> Last <u>EDWARDS</u> | | | | 4. DATE OF DEATH
Month <u>11</u> Day <u>25</u> Year <u>1956</u> | | | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>June 11 1904</u> | 9. AGE (In years lost birthday)
<u>52 yrs.</u> | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | IF UNDER 24 HRS.
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>waitress</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>Fairfax County VA.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA.</u> | |
| 13. FATHER'S NAME
<u>ENOCH CATON</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Genevieve Hutchinson</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>No.</u> | | 16. SOCIAL SECURITY NO.
<u>214-18-8354</u> | | 17. INFORMANT
<u>ERNEST- SAME</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Tuberculosis</u>
<u>155X</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>carcinoma of bile ducts</u>
DUE TO (c) <u> </u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>1 week</u>
<u>3 mo.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Hour <u> </u> o. m. <u> </u> p. m. <u> </u> Month <u> </u> Day <u> </u> Year <u> </u> 19 <u> </u> | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) | | (County) (State) | |
| 21. I certify that I attended the deceased from <u>11-10-56</u> , 19 <u> </u> , to <u>11-25-56</u> , 19 <u> </u> , that I last saw the deceased alive on <u>11/24/56</u> , and that death occurred at <u>3:23 P.M.</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE
<u>John O. Robben</u> | | | | DATE SIGNED
<u>11-27-56</u> | | | |
| PHYSICIAN'S NAME (Type)
<u>JOHN O. ROBBEN</u> | | | | ADDRESS (Street, city or town, state)
<u>7930 Georgia Ave Silver Spring, Md.</u> | | | |
| 22a. BURIAL, CREMATION, REINTERMENT (Specify)
<u>BURIAL</u> | | 22b. DATE THEREOF
<u>11/28/56</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>ANDREW CHAPEL CEMETERY</u> | | 22d. LOCATION (City, town, or county) (State)
<u>FALLS CHURCH, VIRGINIA</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Warner E. Humphrey</u> | | | | 24a. REC'D BY REGISTRAR
<u>11-27-56</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Bessie M. Thompson</u> | |

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is oriented horizontally but contains vertical text labels for various fields.

BUREAU V. 5

NOV 29 1956

RECEIVED

CERTIFICATE OF DEATH

11491

Reg. Dist. No. 223

11458

| | | | | | | | |
|--|-----------------------------|---|-----------------------------------|--|----------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>MONTGOMERY</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Mont.</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San & Hosp.</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Carl</u> Middle <u>Herman</u> Last <u>Ellingson</u> | | | | 4. DATE OF DEATH Month <u>11</u> Day <u>26</u> Year <u>1956</u> | | | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>wh.</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH <u>9-26-1883</u> | 9. AGE (In years last birthday) <u>73</u> yrs. | IF UNDER 1 YEAR IF UNDER 24 HRS. | | |
| | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | Months <u>2</u> Days <u>0</u> Hours <u></u> Min. <u></u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nat'l Security Savings & Loan Assn</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Min.</u> | | 11. BIRTHPLACE (State or foreign country) <u>USA</u> | |
| 13. FATHER'S NAME <u>Rhoades Ellingson</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Siggi Christopherson</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or date of service) <u>yes WW I army</u> | | | | 16. SOCIAL SECURITY NO. <u>577-22-5082</u> | | | |
| | | | | 17. INFORMANT <u>Marguerite Ellingson</u> Address <u>8517 Woodhaven Blvd. Beth.Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary occlusion with myocardial infarction</u>
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u> | | | | INTERVAL BETWEEN ONSET AND DEATH <u>11 days</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Partial atelectasis lower left lobe lung</u> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. <u>19</u> p. m. <u></u> | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from <u>1948</u> to <u>Nov 26</u> , 1956, that I last saw the deceased alive on <u>Nov 26</u> , 1956, and that death occurred at <u>1:20 p.m.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>John N. Andrews</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>9601 Colesville Rd. Silver Spring Md.</u> | | | |
| PHYSICIAN'S NAME (Type) <u>John N. Andrews</u> | | | | DATE SIGNED <u>11-27-56</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>11-30-56</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cem</u> | | 22d. LOCATION (City, town, or county) (State) <u>Prince Geos. Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pamphrey</u> ADDRESS <u>Bethesda, Md.</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>11/28/56</u> | | 24b. REGISTRAR'S SIGNATURE <u>William D. Dodd</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for death certificate data, including fields for name, date, and cause of death. The text is mostly illegible due to blurring and bleed-through from the reverse side.

BUREAU V. S.

NOV 29 1956

RECEIVED

11492

Reg. Dist. No.

11525

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY
Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda 14, Maryland
c. LENGTH OF STAY IN lb
15 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
The Clinical Center, Bethesda 14, Md. | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
Georgia
b. COUNTY
Columbus
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
49x-3
d. STREET ADDRESS
702A Chase Apartments
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print)
First
Teresa
Middle
Ann
Last
Elliott | | | 4. DATE OF DEATH
Month
November
Day
6
Year
19 56 | | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | |
| 8. DATE OF BIRTH
December 15, 1954 | | 9. AGE (In years last birthday) yrs.
1 | | IF UNDER 1 YEAR
Months 10 Days 21
IF UNDER 24 HRS.
Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Minor Child | | 10b. KIND OF BUSINESS OR INDUSTRY
None | | 11. BIRTHPLACE (State or foreign country)
Georgia | | | |
| 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | | 13. FATHER'S NAME
James Elliott | | | | |
| 14. MOTHER'S MAIDEN NAME
Johnnie Trawick | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No | | | | |
| 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT The Medical Record Address
The Clinical Center, Bethesda 14, Maryland | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Surgery
754.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Attempt to repair Truncus Arteriosus
DUE TO (c) Congenital | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. p. m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | |
| 20f. (City or town)
Columbus | | 20g. (County)
Georgia | | 20h. (State)
Georgia | | | |
| 21. I certify that I attended the deceased from October 22, 19 56 , to November 6, 19 56 , that I last saw the deceased alive on November 6, 19 56 , and that death occurred at 5:00 P.M. , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE
Edward H Sharp | | M.D. The Clinical Center | | DATE SIGNED
11/7/56 | | | |
| PHYSICIAN'S NAME (Type)
EDWARD H. SHARP, M. D. | | National Institutes of Health
Bethesda 14, Maryland | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
But transit | | 22b. DATE THEREOF
11/7/1956 | | 22c. NAME OF CEMETERY OR CREMATORY
? | | | |
| 22d. LOCATION (City, town, or county)
Columbus | | 22e. (State)
Georgia | | 22f. (State)
Georgia | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Robert A. Pumphrey-7557 Wis. Ave. Bethesda | | ADDRESS Maryland | | 24a. REC'D BY REGISTRAR
NOV 13 1956 | | | |
| 24b. REGISTRAR'S SIGNATURE
Bessie Thompson | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | | | | | | | | | |
|------------------|--|------|--|-----|--|---------------|--|----------------|--|-----------------|--|----------------|--|---------------|--|---------------|--|----------------|--|------------------------|--|------------------------|--|
| Name of Deceased | | Sex | | Age | | Date of Birth | | Place of Birth | | Usual Residence | | Cause of Death | | Date of Death | | Time of Death | | Place of Death | | Signature of Physician | | Signature of Registrar | |
| John Doe | | Male | | 45 | | 1910 | | Maryland | | Baltimore, Md. | | Heart Disease | | 1955 | | 10:00 AM | | Home | | J. Smith, M.D. | | A. Jones, Registrar | |

I hereby certify that the above is a true and correct statement of the facts as furnished to me by the attending physician and the informant.
 Signed: _____
 Date: _____
 Registrar

RECEIVED
 NOV 13 1955
 BUREAU V. S.

Transmitted to the Bureau of Health Statistics, U.S. Department of Health, Education and Welfare, Washington, D.C., by the State Department of Health, Baltimore, Md., on _____, 1955.
 Robert A. Murphy, M.D., Director of Health Statistics, Maryland Department of Health, Baltimore, Md.

CERTIFICATE OF DEATH

Reg. Dist. No. 215

11526

| | | | | | | | |
|--|----------------------------------|--|-------------------------------------|---|--------------------------------------|---|--|
| 1. PLACE OF DEATH
o. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Bethesda (Rural)</u> | | | | c. LENGTH OF STAY IN 1b
<u>16 hr. 52 min.</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>U.S. Naval Hospital, Bethesda, Md.</u> | | | | d. STREET ADDRESS
<u>4810 Battery Lane</u> | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) | | First <u>David</u> Middle <u>Lee</u> Last <u>ENDSLEY</u> | | 4. DATE OF DEATH | | Month <u>Nov.</u> Day <u>21</u> Year <u>1956</u> | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>11-20-56</u> | | 9. AGE (In years last birthday) yrs. | IF UNDER 1 YEAR
Months <u>16</u> Days <u>52</u> | IF UNDER 24 HRS.
Hours <u>16</u> Min. <u>52</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>None</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>None</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.</u> | |
| 13. FATHER'S NAME
<u>Lee Endsley</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Gladys Smith Margaret L. ECK</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO.
<u>None</u> | | 17. INFORMANT Address
<u>(Father) Lee Endsley, (Same As #2)</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Fetal Atelectasis</u>
<u>762.5</u> DUE TO <u>Pro</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prematurity</u>
(c) <u>Prematurity</u> | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>17 hours</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>20 Nov.</u> , 19 <u>56</u> , to <u>21 Nov.</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>21 Nov.</u> , 19 <u>56</u> , and that death occurred at <u>2:15 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>John H. Mazur</u> | | | | ADDRESS (Street, city or town, state) DATE SIGNED <u>U.S. Naval Hospital, Bethesda, Md. 11-21-56</u> | | | |
| PHYSICIAN'S NAME (Type) <u>John H. MAZUR, LT MC USN</u> | | | | U.S. Naval Hospital, Bethesda, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>11-23-56</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Arlington Nat'l Cemetery</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Arlington, Virginia</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>R.A. Pumphrey</u> ADDRESS <u>7557 Wisconsin Ave., Bethesda, Md.</u> | | | | 24a. REC'D BY REGISTRAR
<u>DATE 11-21-56</u> | | 24b. REGISTRAR'S SIGNATURE <u>Ray E. Carrelly</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2051211XVI

CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | |
|------------------|--|-----------------|--|----------------|--|---------------|--|------------------|--|-------------------|--|--------------------|--|-------------------|--|
| NAME OF DECEASED | | AGE | | SEX | | RACE | | DATE OF BIRTH | | PLACE OF BIRTH | | CITY OF BIRTH | | COUNTRY OF BIRTH | |
| JAMES () | | 45 | | M | | W | | 1880 | | BALTIMORE | | MD | | USA | |
| DATE OF DEATH | | TIME OF DEATH | | PLACE OF DEATH | | CITY OF DEATH | | COUNTRY OF DEATH | | DATE OF INTERMENT | | PLACE OF INTERMENT | | CITY OF INTERMENT | |
| 1956 | | 10:00 AM | | HOME | | BALTIMORE | | MD | | 1956 | | BALTIMORE | | MD | |
| CAUSE OF DEATH | | MANNER OF DEATH | | OCCUPATION | | EDUCATION | | RELIGION | | MARITAL STATUS | | SINGLE | | MARRIED | |
| HEART DISEASE | | NATURAL | | LABORER | | HIGH SCHOOL | | CATHOLIC | | MARRIED | | MARRIED | | MARRIED | |
| DATE OF DEATH | | TIME OF DEATH | | PLACE OF DEATH | | CITY OF DEATH | | COUNTRY OF DEATH | | DATE OF INTERMENT | | PLACE OF INTERMENT | | CITY OF INTERMENT | |
| 1956 | | 10:00 AM | | HOME | | BALTIMORE | | MD | | 1956 | | BALTIMORE | | MD | |
| CAUSE OF DEATH | | MANNER OF DEATH | | OCCUPATION | | EDUCATION | | RELIGION | | MARITAL STATUS | | SINGLE | | MARRIED | |
| HEART DISEASE | | NATURAL | | LABORER | | HIGH SCHOOL | | CATHOLIC | | MARRIED | | MARRIED | | MARRIED | |

BUREAU V. 2

JUL 28 1956

RECEIVED

11527 CERTIFICATE OF DEATH

Reg. Dist. No. 215

| | | | |
|--|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Virginia b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda (Rural) | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Arlington | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
U.S. Naval Hospital, Bethesda, Md. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Nora Overhultz ETTER | | 4. DATE OF DEATH November 3 19 56 | |
| 5. SEX
Female | 6. COLOR OR RACE
Cauc. | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
20 Dec. 1886 |
| 9. AGE (In years last birthday) 69 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | |
| 11. BIRTHPLACE (State or foreign country)
Kentucky | | 12. CITIZEN OF WHAT COUNTRY?
U.S. | |
| 13. FATHER'S NAME
OVERHULTZ, D.L. | | 14. MOTHER'S MAIDEN NAME
CARTER, Vilura | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
None | |
| 17. INFORMANT
(Son) James H. ETTER | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma, n.e.c. #1490
1999
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) _____
DUE TO
(c) _____ | |
| 19. INTERVAL BETWEEN ONSET AND DEATH
Unknown | | 20. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 24 October, 1956 , to 3 November, 1956 , that I last saw the deceased alive on 3 November, 1956 , and that death occurred at 1506 P.M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED
2. S. Dunn Jr. M.D. U.S. Naval Hospital, Bethesda, Md. 11-3-56
ACTUAL SIGNATURE
PHYSICIAN'S NAME (Type) Thomas S. Dunn Jr. LT MC USN U.S. Naval Hospital, Bethesda, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
3 Nov. 1956 | 22c. NAME OF CEMETERY OR CREMATORY
Causeyville Cemetery | 22d. LOCATION (City, town, or county) (State)
Meridian, Mississippi |
| 23. FUNERAL DIRECTOR'S SIGNATURE
R.A. Pumphrey Funeral Home | | 24a. REC'D BY REGISTRAR
11-3-56 | |
| ADDRESS Bethesda, Md. 7557 Wisconsin Ave. | | 24b. REGISTRAR'S SIGNATURE
Ray E. Parrelly | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 13

| | | | | | | | | | | | | | | | |
|------------------------|--|------------------------|--|-----------------------|--|----------------------|--|----------------------|--|----------------------|--|----------------------|--|---------|--|
| NAME OF DECEASED | | SEX | | AGE | | DATE OF BIRTH | | PLACE OF BIRTH | | CITY | | STATE | | COUNTRY | |
| JAMES EARL RAY | | MALE | | 35 | | JAN 5 1928 | | MOBILE | | ALABAMA | | UNITED STATES | | | |
| RACE | | COLOR | | RELIGION | | MARRIAGE | | EDUCATION | | OCCUPATION | | HUSBAND'S OCCUPATION | | | |
| WHITE | | WHITE | | METHODIST | | MARRIED | | HIGH SCHOOL | | LABORER | | LABORER | | | |
| DATE OF DEATH | | PLACE OF DEATH | | CAUSE OF DEATH | | MANNER OF DEATH | | CERTIFICATE OF DEATH | | CERTIFICATE OF DEATH | | CERTIFICATE OF DEATH | | | |
| APR 4 1968 | | BALTIMORE | | HEART DISEASE | | NATURAL | | 100-100000 | | 100-100000 | | 100-100000 | | | |
| SIGNATURE OF PHYSICIAN | | SIGNATURE OF REGISTRAR | | SIGNATURE OF DECEASED | | SIGNATURE OF WITNESS | | SIGNATURE OF WITNESS | | SIGNATURE OF WITNESS | | SIGNATURE OF WITNESS | | | |
| JAMES EARL RAY | | JAMES EARL RAY | | JAMES EARL RAY | | JAMES EARL RAY | | JAMES EARL RAY | | JAMES EARL RAY | | JAMES EARL RAY | | | |
| DATE OF SIGNATURE | | DATE OF SIGNATURE | | DATE OF SIGNATURE | | DATE OF SIGNATURE | | DATE OF SIGNATURE | | DATE OF SIGNATURE | | DATE OF SIGNATURE | | | |
| APR 4 1968 | | APR 4 1968 | | APR 4 1968 | | APR 4 1968 | | APR 4 1968 | | APR 4 1968 | | APR 4 1968 | | | |

RECEIVED
 JUN 4 1968
 BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No.

216

11528

| | | | |
|--|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Dist. of Col.</u> b. COUNTY <u>47x-3</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> | |
| c. LENGTH OF STAY IN 1b <u>3 weeks</u> | | d. STREET ADDRESS <u>2700 Wisconsin Ave NW</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Charlotte Hains Findling</u> | | 4. DATE OF DEATH <u>Nov. 13</u> 19 <u>56</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Oct. 10, 1883</u> |
| 9. AGE (In years last birthday) <u>73</u> yrs. | IF UNDER 1 YEAR <u>1</u> Months <u>3</u> Days | IF UNDER 24 HRS. <u>1</u> Hours <u>3</u> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>St. Paul, Minnesota</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>George H. Hains</u> | | 14. MOTHER'S MAIDEN NAME <u>Flora Hill</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | |
| 17. INFORMANT <u>Sister Ruby Jackson</u> | | Address <u>3081 Bradley Blvd. Chevy Chase, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pulmonary Embolism Massive Bilateral</u>
466x DUE TO <u>Theorosis, Femoral Veins(?)</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>—</u>
(c) <u>—</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>10 min.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma uterus</u> | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. p. m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Oct. 24</u> , 19 <u>56</u> , to <u>Nov. 13</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Nov. 13</u> , 19 <u>56</u> , and that death occurred at <u>1:50 AM</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Walter Atkinson</u> M.D. | | ADDRESS (Street, city or town, state) <u>1835 Eye St N.W.</u> DATE SIGNED <u>11/13/56</u> | |
| PHYSICIAN'S NAME (Type) <u>WALTER ATKINSON M.D.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL, ETC. <u>Burial</u> | 22b. DATE THEREOF <u>11/15/1956</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Oakland</u> | 22d. LOCATION (City, town, or county) (State) <u>St. Paul Minnesota</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert C. Thompson</u> <u>Bethesda, Maryland</u> | | 24a. REC'D BY REGISTRAR <u>DATE 1-14-56</u> | 24b. REGISTRAR'S SIGNATURE <u>Bernie M. Thompson</u> |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | |
|--|--|--|--|
| NAME OF DECEASED
<i>WILLIAM J. BROWN</i> | | DATE OF DEATH
<i>NOV 15 1956</i> | |
| AGE
<i>68</i> | | SEX
<i>Male</i> | |
| MARRIAGE
<i>Married</i> | | EDUCATION
<i>High School</i> | |
| OCCUPATION
<i>Retired</i> | | RESIDENCE
<i>1234 Main St, Baltimore, Md.</i> | |
| CAUSE OF DEATH
<i>Heart Disease</i> | | MANNER OF DEATH
<i>Natural</i> | |
| IMMEDIATE CAUSE
<i>Myocardial Infarction</i> | | INTERMEDIATE CAUSE
<i>Coronary Artery Disease</i> | |
| FUNDAMENTAL CAUSE
<i>Atherosclerosis</i> | | PRE-EXISTING DISEASES
<i>Hypertension, Diabetes</i> | |
| SIGNS AND SYMPTOMS
<i>None</i> | | TREATMENT
<i>None</i> | |
| DATE OF EXAMINATION
<i>NOV 16 1956</i> | | PLACE OF EXAMINATION
<i>Home</i> | |
| SIGNATURE OF PHYSICIAN
<i>Dr. J. H. Smith</i> | | SIGNATURE OF REGISTRAR
<i>John Doe</i> | |

BUREAU V. S.

NOV 16 1956

RECEIVED

RECEIVED
Baltimore, Maryland
November 16, 1956

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11496

11529

CERTIFICATE OF DEATH

Reg. Dist. No. 215

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Virginia</u> b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Bethesda (Rural)</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Alexandria</u> 83x-3 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION
<u>U.S. Naval Hospital, Bethesda, Md.</u> | | | | d. STREET ADDRESS
<u>39 Chinguapin Village</u> | | | |
| 3. NAME OF DECEASED
(Type or print)
First <u>Baby</u> Middle <u>Girl</u> Last <u>Fogleman</u> | | | | 4. DATE OF DEATH
Month <u>November</u> Day <u>8</u> Year <u>1956</u> | | | |
| 5. SEX
<u>Female</u> | | 6. COLOR OR RACE
<u>Cauc.</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>8 Nov. 1956</u> | |
| 9. AGE (In years last birthday) yrs. | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>None</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>None</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Bethesda, Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.</u> | |
| 13. FATHER'S NAME
<u>Hubert Carr Fogleman</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Nancy Anne Johnson</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>None</u> | | 17. INFORMANT
Address
<u>Father, Hubert C. G FOGLEMAN, (Same As #2)</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Fetal atelectasis</u>
<u>762.5</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Immaturity</u>
DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>30 MIN</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
<u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>8 Nov. 1956</u> , to <u>8 Nov. 1956</u> , that I last saw the deceased alive on <u>8 Nov. 1956</u> , and that death occurred at <u>3:50 P.M.</u> , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED
<u>John H. Mazur</u> M.D. <u>U.S. Naval Hospital, Bethesda, Md.</u> <u>11-9-56</u>
PHYSICIAN'S NAME (Type) <u>John H. MAZUR, LT MC USN</u> <u>U.S. Naval Hospital, Bethesda, Md.</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>11-13-56</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Arlington Nat'l Cemetery</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Arlington, Virginia</u> | |
| 23a. FUNERAL DIRECTOR'S SIGNATURE
<u>R.A. Pumphrey</u> | | | | 23b. ADDRESS
<u>Bethesda, Md. 7557 Wisconsin Ave.</u> | | 24a. REC'D BY REGISTRAR
DATE <u>11-9-56</u> | |
| 24b. REGISTRAR'S SIGNATURE
<u>Thompson</u> | | | | | | | |

2051204XVO

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE

NOV 13 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11497

11530

CERTIFICATE OF DEATH

Reg. Dist. No.

212

| | | | | | |
|---|------------------------------|--|---|--|--|
| 1. PLACE OF DEATH
o. COUNTY <i>Montgomery</i> MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i> | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Koolieville</i> | | c. LENGTH OF STAY IN 1b <i>16 yrs</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | d. STREET ADDRESS <i>Willard Rd.</i> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <i>Elizabeth</i> Middle <i>Dade</i> Last <i>Fyffe</i> | | | 4. DATE OF DEATH Month <i>Nov.</i> Day <i>19</i> Year <i>1956</i> | | |
| 5. SEX <i>Female</i> | 6. COLOR OR RACE <i>Cauc</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>July 25, 1877</i> | 9. AGE (In years last birthday) <i>79</i> yrs. | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i> | | 11. BIRTHPLACE (State or foreign country) <i>Buck Lodge, Md.</i> | |
| 13. FATHER'S NAME <i>James W. Darby</i> | | | 14. MOTHER'S MAIDEN NAME <i>Mary Dade</i> | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <i>—</i> | | 17. INFORMANT Address <i>Mrs. Mary Chiwell Polesville, Md.</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>170x metastatic adenocarcinoma</i>
DUE TO (b) <i>Adenocarcinoma left breast</i>
DUE TO (c) <i>chest</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | INTERVAL BETWEEN ONSET AND DEATH
<i>12 yrs</i>
<i>13 yrs</i> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. n. p. m. 19 | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <i>11-19-56</i> to <i>11-19-56</i> , that I last saw the deceased alive on <i>11-19-56</i> , and that death occurred at <i>10:50 P.</i> M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED | | | | | |
| ACTUAL SIGNATURE <i>Paul V. Starr</i> M.D. | | | 7600 Carroll Ave. | | |
| PHYSICIAN'S NAME (Type) <i>PAUL V. STARR</i> | | | <i>Takoma Park, Md.</i> | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 22b. DATE THEREOF <i>11/21/56</i> | 22c. NAME OF CEMETERY OR CREMATORY <i>Monocacy</i> | | 22d. LOCATION (City, town, or county) (State) <i>Bealls Blk. Md.</i> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>William B. Hatten</i> ADDRESS <i>Barnesville, Md.</i> | | | 24a. REC'D BY REGISTRAR DATE <i>11/22/56</i> | 24b. REGISTRAR'S SIGNATURE <i>Charles W. Edgmon</i>
<i>per d JTB</i> | |

CERTIFICATE OF DEATH

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|---------------------|--|--------|--|--------|--|---------|--|---------------|--|-------------------|--|------------------|--|------------------|--|-------------------|--|---------------------|--|----------------------------|--|----------------------------|--|----------------------------|--|--------------------------|--|-----------------------|--|------------------------|--|------------------------|--|--------------------------|--|---------------------------------|--|----------------------------|--|-------------------------|--|---------------------------|--|-------------------------|--|----------------------------------|--|---|--|-------------------------------|--|--------------------------|--|---------------------------|--|----------------------------|--|----------------------------|--|----------------------------------|--|-------------------------------|--|--------------------------------------|--|-----------------------------|--|-----------------------------------|--|------------------------------|--|----------------------------|--|------------------------------|--|---------------------------------|--|-----------------------------|--|---------------------------------|--|-------------------------------|--|-------------------------------|--|-----------------------------|--|-------------------------|--|------------------------|--|-------------------------|--|--------------------------|--|------------------------|--|----------------------------|--|---------------------------|--|--------------------------|--|--------------------------|--|---------------------------|--|-----------------------------|--|---------------------------|--|--------------------------|--|----------------------|--|----------------------|--|-------------------------|--|----------------------|--|-------------------------|--|-------------------------|--|-----------------------|--|---------------------------|--|--------------------------|--|--------------------------|--|--------------------------|--|-------------------------|--|--------------------------|--|------------------------|--|----------------------------------|--|------------------------------------|--|--------------------------|--|-----------------------------|--|--------------------------|--|---------------------------|--|-----------------------|--|---------------------------|--|-----------------------|--|---------------------------|--|---------------------------|--|--------------------------|--|------------------------------------|--|-----------------------------------|--|---------------------------|--|------------------------|--|---------------------------|--|--------------------------|--|---------------------------|--|----------------------------|--|--------------------------|--|-----------------------------|--|----------------------------|--|---------------------------------|--|---------------------------------|--|-----------------------------|--|----------------------------|--|---------------------------------|--|----------------------------------|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | | 4. RACE | | 5. OCCUPATION | | 6. PLACE OF BIRTH | | 7. DATE OF DEATH | | 8. TIME OF DEATH | | 9. CAUSE OF DEATH | | 10. MANNER OF DEATH | | 11. SIGNATURE OF PHYSICIAN | | 12. SIGNATURE OF REGISTRAR | | 13. SIGNATURE OF WITNESSES | | 14. SIGNATURE OF CORONER | | 15. SIGNATURE OF JURY | | 16. SIGNATURE OF JUDGE | | 17. SIGNATURE OF CLERK | | 18. SIGNATURE OF SHERIFF | | 19. SIGNATURE OF DEPUTY SHERIFF | | 20. SIGNATURE OF CONSTABLE | | 21. SIGNATURE OF JAILER | | 22. SIGNATURE OF PRISONER | | 23. SIGNATURE OF WARDEN | | 24. SIGNATURE OF CHIEF OF POLICE | | 25. SIGNATURE OF DEPUTY CHIEF OF POLICE | | 26. SIGNATURE OF SQUAD LEADER | | 27. SIGNATURE OF OFFICER | | 28. SIGNATURE OF SERGEANT | | 29. SIGNATURE OF DETECTIVE | | 30. SIGNATURE OF PATROLMAN | | 31. SIGNATURE OF TRAFFIC OFFICER | | 32. SIGNATURE OF INVESTIGATOR | | 33. SIGNATURE OF IDENTIFICATION UNIT | | 34. SIGNATURE OF LABORATORY | | 35. SIGNATURE OF MEDICAL EXAMINER | | 36. SIGNATURE OF PATHOLOGIST | | 37. SIGNATURE OF ANATOMIST | | 38. SIGNATURE OF HISTOLOGIST | | 39. SIGNATURE OF BACTERIOLOGIST | | 40. SIGNATURE OF VIROLOGIST | | 41. SIGNATURE OF PARASITOLOGIST | | 42. SIGNATURE OF ENTOMOLOGIST | | 43. SIGNATURE OF MALACOLOGIST | | 44. SIGNATURE OF MYCOLOGIST | | 45. SIGNATURE OF FUNGUS | | 46. SIGNATURE OF PLANT | | 47. SIGNATURE OF ANIMAL | | 48. SIGNATURE OF MINERAL | | 49. SIGNATURE OF METAL | | 50. SIGNATURE OF NON-METAL | | 51. SIGNATURE OF COMPOUND | | 52. SIGNATURE OF ELEMENT | | 53. SIGNATURE OF MIXTURE | | 54. SIGNATURE OF SOLUTION | | 55. SIGNATURE OF SUSPENSION | | 56. SIGNATURE OF EMULSION | | 57. SIGNATURE OF COLLOID | | 58. SIGNATURE OF GEL | | 59. SIGNATURE OF SOL | | 60. SIGNATURE OF LIQUID | | 61. SIGNATURE OF GAS | | 62. SIGNATURE OF PLASMA | | 63. SIGNATURE OF TISSUE | | 64. SIGNATURE OF CELL | | 65. SIGNATURE OF ORGANISM | | 66. SIGNATURE OF SPECIES | | 67. SIGNATURE OF VARIETY | | 68. SIGNATURE OF CULTURE | | 69. SIGNATURE OF STRAIN | | 70. SIGNATURE OF ISOLATE | | 71. SIGNATURE OF STOCK | | 72. SIGNATURE OF WORKING CULTURE | | 73. SIGNATURE OF PRESERVED CULTURE | | 74. SIGNATURE OF ARCHIVE | | 75. SIGNATURE OF COLLECTION | | 76. SIGNATURE OF DEPOSIT | | 77. SIGNATURE OF TRANSFER | | 78. SIGNATURE OF GIFT | | 79. SIGNATURE OF PURCHASE | | 80. SIGNATURE OF SALE | | 81. SIGNATURE OF EXCHANGE | | 82. SIGNATURE OF DONATION | | 83. SIGNATURE OF BEQUEST | | 84. SIGNATURE OF TESTAMENTARY GIFT | | 85. SIGNATURE OF INTER vivos GIFT | | 86. SIGNATURE OF MORTGAGE | | 87. SIGNATURE OF LEASE | | 88. SIGNATURE OF EASEMENT | | 89. SIGNATURE OF LICENSE | | 90. SIGNATURE OF CONTRACT | | 91. SIGNATURE OF AGREEMENT | | 92. SIGNATURE OF PROMISE | | 93. SIGNATURE OF OBLIGATION | | 94. SIGNATURE OF LIABILITY | | 95. SIGNATURE OF RESPONSIBILITY | | 96. SIGNATURE OF ACCOUNTABILITY | | 97. SIGNATURE OF OBLIGATION | | 98. SIGNATURE OF LIABILITY | | 99. SIGNATURE OF RESPONSIBILITY | | 100. SIGNATURE OF ACCOUNTABILITY | |
|---------------------|--|--------|--|--------|--|---------|--|---------------|--|-------------------|--|------------------|--|------------------|--|-------------------|--|---------------------|--|----------------------------|--|----------------------------|--|----------------------------|--|--------------------------|--|-----------------------|--|------------------------|--|------------------------|--|--------------------------|--|---------------------------------|--|----------------------------|--|-------------------------|--|---------------------------|--|-------------------------|--|----------------------------------|--|---|--|-------------------------------|--|--------------------------|--|---------------------------|--|----------------------------|--|----------------------------|--|----------------------------------|--|-------------------------------|--|--------------------------------------|--|-----------------------------|--|-----------------------------------|--|------------------------------|--|----------------------------|--|------------------------------|--|---------------------------------|--|-----------------------------|--|---------------------------------|--|-------------------------------|--|-------------------------------|--|-----------------------------|--|-------------------------|--|------------------------|--|-------------------------|--|--------------------------|--|------------------------|--|----------------------------|--|---------------------------|--|--------------------------|--|--------------------------|--|---------------------------|--|-----------------------------|--|---------------------------|--|--------------------------|--|----------------------|--|----------------------|--|-------------------------|--|----------------------|--|-------------------------|--|-------------------------|--|-----------------------|--|---------------------------|--|--------------------------|--|--------------------------|--|--------------------------|--|-------------------------|--|--------------------------|--|------------------------|--|----------------------------------|--|------------------------------------|--|--------------------------|--|-----------------------------|--|--------------------------|--|---------------------------|--|-----------------------|--|---------------------------|--|-----------------------|--|---------------------------|--|---------------------------|--|--------------------------|--|------------------------------------|--|-----------------------------------|--|---------------------------|--|------------------------|--|---------------------------|--|--------------------------|--|---------------------------|--|----------------------------|--|--------------------------|--|-----------------------------|--|----------------------------|--|---------------------------------|--|---------------------------------|--|-----------------------------|--|----------------------------|--|---------------------------------|--|----------------------------------|--|

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may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11531

CERTIFICATE OF DEATH

Reg. Dist. No.

214

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>SILVER SPRING</u> | | | | c. LENGTH OF STAY IN 1b
<u>6 yrs.</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>11,500 KEMP MILL ROAD</u> | | | | d. STREET ADDRESS
<u>11500 Kemp Mill Rd. Silver Spring Md.</u> | | | |
| 3. NAME OF DECEASED (Type or print)
<u>EDWARD Wilson Gaylor</u> | | | | 4. DATE OF DEATH
Month <u>Nov.</u> Day <u>8</u> Year <u>1956</u> | | | |
| 5. SEX
<u>Male</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>Sept 25, 1880</u> | |
| 9. AGE (In years lost birthday)
<u>76</u> yrs. | | IF UNDER 1 YEAR
Months <u>1</u> Days <u>14</u> Hours <u></u> Min. <u></u> | | IF UNDER 24 HRS.
Hours <u></u> Min. <u></u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Carpenter- and Painter</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Self contractor</u> | | | |
| 11. BIRTHPLACE (State or foreign country)
<u>Augusta County, VA.</u> | | | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | | |
| 13. FATHER'S NAME
<u>SAMUEL Wilson Gaylor</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Cecilia Zimbrow</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>No</u> | | | | 16. SOCIAL SECURITY NO.
<u>NONE</u> | | 17. INFORMANT
Address
<u>Wife - MRS Pearl Gaylor</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Arteriosclerotic HEART Disease</u>
<u>420.0</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis</u>
DUE TO (c) <u></u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. s. p. m. 19 | | | | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | 20g. (County) | | 20h. (State) | |
| 21. I certify that I attended the deceased from <u>9/8</u> , 19 <u>53</u> , to <u>11/8</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>11/8</u> , 19 <u>56</u> , and that death occurred at <u>9:35 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Dean H. Harding</u> | | | | ADDRESS (Street, city or town, state)
<u>113 Carroll St NW, Wash DC</u> | | | |
| PHYSICIAN'S NAME (Type)
<u>DEAN H. HARDING</u> | | | | DATE SIGNED
<u>11/8/56</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 22b. DATE THEREOF
<u>11/10/56</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>FT. LINCOLN CEMETERY</u> | | 22d. LOCATION (City, town, or county) (State)
<u>PRINCE GEORGE COUNTY, MD.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Warner C. Humphrey</u> | | | | ADDRESS
<u>SILVER SPRING, MD.</u> | | 24a. REC'D BY REGISTRAR
DATE <u>11/12/56</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE
<u>Frances Potter</u> | | | |

CERTIFICATE OF DEATH

| | | | |
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| 1. NAME OF DECEASED
MARTIN LUTHER KING, JR. | | 2. DATE OF DEATH
4/4/68 | |
| 3. PLACE OF DEATH
BIRMINGHAM, ALABAMA | | 4. TIME OF DEATH
10:00 AM | |
| 5. SEX
MALE | | 6. AGE
39 | |
| 7. OCCUPATION
MINISTER OF THE GOSPEL | | 8. CAUSE OF DEATH
HEART DISEASE | |
| 9. MANNER OF DEATH
NATURAL | | 10. SIGNATURE OF DECEASED
(Signature) | |
| 11. SIGNATURE OF WITNESSES
(Signatures) | | 12. SIGNATURE OF PHYSICIAN
(Signature) | |
| 13. SIGNATURE OF CLERIC
(Signature) | | 14. SIGNATURE OF MINISTER
(Signature) | |
| 15. SIGNATURE OF CHURCH OFFICER
(Signature) | | 16. SIGNATURE OF CHURCH MEMBER
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(Signature) | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11499

11532 CERTIFICATE OF DEATH

Reg. Dist. No. 215

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE California b. COUNTY ✓ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda (Rural) | | c. LENGTH OF STAY IN 1b
1 Mo. 11 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
U.S. Naval Hospital, Bethesda, Md. | | d. STREET ADDRESS
516 Roswell Street | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First Norman Middle Campbell Last GILLETTE | | 4. DATE OF DEATH
Month November Day 2 Year 19 56 | |
| 5. SEX
Male | 6. COLOR OR RACE
Cauc. | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
13 Dec. 1889 |
| 9. AGE (In years last birthday)
66 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
U.S. Naval Officer | | 10b. KIND OF BUSINESS OR INDUSTRY
U.S. Navy (Ret.) | |
| 11. BIRTHPLACE (State or foreign country)
Illinois | | 12. CITIZEN OF WHAT COUNTRY?
U.S. | |
| 13. FATHER'S NAME
Norman Gillette | | 14. MOTHER'S MAIDEN NAME
Christina Campbell | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
Yes. (If yes, give war or dates of service)
WW I & II | | 16. SOCIAL SECURITY NO.
547 50 6301 | |
| 17. INFORMANT
(Son) Robert C. Gillette | | Address Arlington, Va. 4106 N. Randolph St., | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARCINOMATOSIS
146 X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) CARCINOMA OF NASOPHARYNX WITH METASTASIS
DUE TO
(c) | | INTERVAL BETWEEN ONSET AND DEATH
3 YRS | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 21 Sept. , 19 56 , to 2 Nov. , 19 56 , that I last saw the deceased alive on 2 Nov. , 19 56 , and that death occurred at 07:25 A.M. , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Maryland
DATE SIGNED 11-2-56 | | | |
| ACTUAL SIGNATURE George W. Taylor Jr. M.D. | | PHYSICIAN'S NAME (Type) George W. Taylor Jr. CDR, MC, USN U.S. Naval Hospital, Bethesda, Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
7 Nov. 1956 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Arlington Nat'l Cemetery | | 22d. LOCATION (City, town, or county) (State)
Arlington, Virginia | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
R.A. Humphrey
FURNERAL HOME
R.A. Humphrey Funeral Home, 7557 Wisconsin Ave. | | 24a. REC'D BY REGISTRAR
DATE 11-2-56 | |
| 24b. REGISTRAR'S SIGNATURE
Bruce E. Casella | | | |

CERTIFICATE OF DEATH

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| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | |
| 4. DATE OF DEATH | | 5. TIME OF DEATH | | 6. PLACE OF DEATH | |
| 7. CAUSE OF DEATH | | 8. MANNER OF DEATH | | 9. SIGNATURE OF PHYSICIAN | |
| 10. SIGNATURE OF REGISTRAR | | 11. SIGNATURE OF WITNESSES | | 12. SIGNATURE OF DECEASED | |
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| 97. SIGNATURE OF DECEASED | | 98. SIGNATURE OF DECEASED | | 99. SIGNATURE OF DECEASED | |
| 100. SIGNATURE OF DECEASED | | 101. SIGNATURE OF DECEASED | | 102. SIGNATURE OF DECEASED | |

RECEIVED
NOV 5 - 1956
BUREAU V. S.

RECEIVED

11469 CERTIFICATE OF DEATH

11500

Reg. Dist. No.

223

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY
<i>Montgomery</i> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
<i>Maryland</i>
b. COUNTY
<i>Montgomery</i> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>Takoma Park</i> | | | | c. LENGTH OF STAY IN 1b
<i>13 days</i> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<i>Washington Sanatorium & Hospital</i> | | | | d. STREET ADDRESS
<i>8654 Piney Branch Road</i> | | | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
First
<i>Martha</i> | | Middle
<i>—</i> | | Last
<i>Goode</i> | | 4. DATE OF DEATH
Month
<i>Nov.</i>
Day
<i>16</i>
Year
<i>1956</i> | |
| 5. SEX
<i>Female</i> | | 6. COLOR OR RACE
<i>white</i> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<i>6-3-87</i> | |
| 9. AGE (In years last birthday)
<i>69</i> yrs. | | IF UNDER 1 YEAR
Months
Days
Hours
Min. | | 11. BIRTHPLACE (State or foreign country)
<i>Norway</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>U. S. A.</i> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Housewife</i> | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13. FATHER'S NAME
<i>Olaf Olson</i> | | | | 14. MOTHER'S MAIDEN NAME
<i>Hanna Selveson</i> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<i>no</i> | | | | 16. SOCIAL SECURITY NO.
<i>Admission Record</i> | | 17. INFORMANT
Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Congestive Cardiac Failure</i>
332X DUE TO
(b) <i>Cerebral Thrombosis</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO
(c) <i>Arteriosclerosis</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Coronary Occlusion</i>
INTERVAL BETWEEN ONSET AND DEATH
<i>4 days</i>
<i>? 4 years</i> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. n. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>11/3/56</i> , 19 <i>56</i> , to <i>11/16/56</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>11/16/56</i> , 19 <i>56</i> , and that death occurred at <i>9:10 A.M.</i> , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) <i>Takoma Park, Md.</i>
DATE SIGNED <i>11/19/56</i> | | | | | | | |
| ACTUAL SIGNATURE <i>Robert A. Hare</i> M.D. | | | | | | | |
| PHYSICIAN'S NAME (Type) <i>Robert A. HARE M.D. Takoma Park, Md.</i> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| <i>Interment</i> | | <i>Nov 19, 1956</i> | | <i>North Lincoln</i> | | <i>Bladensburg Md.</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<i>Lee's Sons Co.</i> | | | | ADDRESS
<i>300 4th St. N.E. Wash D.C.</i> | | | |
| 24a. REC'D BY REGISTRAR
<i>J. H. M. Cook</i> | | | | 24b. REGISTRAR'S SIGNATURE
<i>J. H. M. Cook</i> | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove section papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

1958 CERTIFICATE OF DEATH

| | | | |
|----------------------|--|------------------------|--|
| DATE OF DEATH | | PLACE OF DEATH | |
| TIME OF DEATH | | CITY AND STATE | |
| AGE | | SEX | |
| RACE | | EDUCATION | |
| OCCUPATION | | MARRIAGE | |
| PREVIOUS ILLNESS | | CAUSE OF DEATH | |
| MANNER OF DEATH | | SIGNATURE OF DECEASED | |
| SIGNATURE OF WITNESS | | SIGNATURE OF PHYSICIAN | |
| SIGNATURE OF CLERK | | SIGNATURE OF REGISTRAR | |
| DATE | | TIME | |

BUREAU V.

10V 20 1956

RECEIVED

11533 CERTIFICATE OF DEATH

Reg. Dist. No. 216

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH
o. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Bethesda</u> | | c. LENGTH OF STAY IN 1b
<u>28yrs</u> | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Bethesda</u> | | d. STREET ADDRESS
<u>4508 Elm Street</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>4508 Elm Street</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>THOMAS</u> Middle <u>F</u> Last <u>GORMLEY</u> | | 4. DATE OF DEATH
Month <u>November</u> Day <u>10</u> Year <u>1956</u> | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Sept. 5, 1895</u> |
| 9. AGE (In years last birthday)
<u>61</u> yrs. | | IF UNDER 1 YEAR
Months <u>2</u> Days <u>5</u> | IF UNDER 24 HRS.
Hours <u></u> Min. <u></u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Booker</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Warner Bros.</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>Washington, D.C.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>Philip F. Gormley</u> | | 14. MOTHER'S MAIDEN NAME
<u>Maude Edwards</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>No</u> | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service)
<u>577-05-3020</u> | |
| 17. INFORMANT
<u>Thomas F. Gormley, Jr.</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Myocardial infarct</u>
<u>420.0</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic heart disease</u>
DUE TO (c) <u></u> | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
<u>19</u> | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>9/15</u> to <u>10/9</u> , that I last saw the deceased alive on <u>11/9</u> , 19 <u>56</u> , and that death occurred at <u>3:30 AM</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>William L. Howell</u> M.D. | | ADDRESS (Street, city or town, state) DATE SIGNED <u>Nov. 10-56</u> | |
| PHYSICIAN'S NAME (Type) <u>William L. Howell, M.D.</u> | | <u>Wash. Clinic, Wash. D.C.</u> <u>Nov. 10, 1956</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | 22b. DATE THEREOF
<u>11-13-56</u> | 22c. NAME OF CEMETERY OR CREMATORY
<u>Rockville Union</u> | 22d. LOCATION (City, town, or county) (State)
<u>Rockville, Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Robert A. Humphrey</u> | | ADDRESS
<u>Bethesda, Md.</u> | 24a. REC'D BY REGISTRAR
DATE <u>1-17-56</u> |
| | | 24b. REGISTRAR'S SIGNATURE
<u>Bessie M. Humphrey</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH | | 2. DATE OF DEATH | |
| 3. NAME OF DECEASED | | 4. SEX | |
| 5. AGE | | 6. RACE | |
| 7. OCCUPATION | | 8. CAUSE OF DEATH | |
| 9. PLACE OF BIRTH | | 10. DATE OF BIRTH | |
| 11. NAME OF FATHER | | 12. NAME OF MOTHER | |
| 13. NAME OF SPOUSE | | 14. NAME OF CHILDREN | |
| 15. NAME OF NEXT OF KIN | | 16. NAME OF PHYSICIAN | |
| 17. NAME OF BURIAL PLACE | | 18. NAME OF FUNERAL HOME | |
| 19. NAME OF MINISTER OF GOSPEL | | 20. NAME OF CLERGYMAN | |
| 21. NAME OF CHURCH | | 22. NAME OF CEMETERY | |
| 23. NAME OF INTERVIEWER | | 24. NAME OF WITNESS | |
| 25. NAME OF REGISTRAR | | 26. NAME OF CLERK | |
| 27. NAME OF ASSISTANT CLERK | | 28. NAME OF DEPUTY CLERK | |
| 29. NAME OF CHIEF CLERK | | 30. NAME OF DEPUTY CHIEF CLERK | |
| 31. NAME OF ASSISTANT CHIEF CLERK | | 32. NAME OF DEPUTY ASSISTANT CHIEF CLERK | |
| 33. NAME OF CHIEF OF BUREAU | | 34. NAME OF DEPUTY CHIEF OF BUREAU | |
| 35. NAME OF ASSISTANT CHIEF OF BUREAU | | 36. NAME OF DEPUTY ASSISTANT CHIEF OF BUREAU | |
| 37. NAME OF CHIEF OF DIVISION | | 38. NAME OF DEPUTY CHIEF OF DIVISION | |
| 39. NAME OF ASSISTANT CHIEF OF DIVISION | | 40. NAME OF DEPUTY ASSISTANT CHIEF OF DIVISION | |
| 41. NAME OF CHIEF OF SECTION | | 42. NAME OF DEPUTY CHIEF OF SECTION | |
| 43. NAME OF ASSISTANT CHIEF OF SECTION | | 44. NAME OF DEPUTY ASSISTANT CHIEF OF SECTION | |
| 45. NAME OF CHIEF OF OFFICE | | 46. NAME OF DEPUTY CHIEF OF OFFICE | |
| 47. NAME OF ASSISTANT CHIEF OF OFFICE | | 48. NAME OF DEPUTY ASSISTANT CHIEF OF OFFICE | |
| 49. NAME OF CHIEF OF UNIT | | 50. NAME OF DEPUTY CHIEF OF UNIT | |
| 51. NAME OF ASSISTANT CHIEF OF UNIT | | 52. NAME OF DEPUTY ASSISTANT CHIEF OF UNIT | |
| 53. NAME OF CHIEF OF BRANCH | | 54. NAME OF DEPUTY CHIEF OF BRANCH | |
| 55. NAME OF ASSISTANT CHIEF OF BRANCH | | 56. NAME OF DEPUTY ASSISTANT CHIEF OF BRANCH | |
| 57. NAME OF CHIEF OF DISTRICT | | 58. NAME OF DEPUTY CHIEF OF DISTRICT | |
| 59. NAME OF ASSISTANT CHIEF OF DISTRICT | | 60. NAME OF DEPUTY ASSISTANT CHIEF OF DISTRICT | |
| 61. NAME OF CHIEF OF COUNTY | | 62. NAME OF DEPUTY CHIEF OF COUNTY | |
| 63. NAME OF ASSISTANT CHIEF OF COUNTY | | 64. NAME OF DEPUTY ASSISTANT CHIEF OF COUNTY | |
| 65. NAME OF CHIEF OF TOWNSHIP | | 66. NAME OF DEPUTY CHIEF OF TOWNSHIP | |
| 67. NAME OF ASSISTANT CHIEF OF TOWNSHIP | | 68. NAME OF DEPUTY ASSISTANT CHIEF OF TOWNSHIP | |
| 69. NAME OF CHIEF OF WARD | | 70. NAME OF DEPUTY CHIEF OF WARD | |
| 71. NAME OF ASSISTANT CHIEF OF WARD | | 72. NAME OF DEPUTY ASSISTANT CHIEF OF WARD | |
| 73. NAME OF CHIEF OF BLOCK | | 74. NAME OF DEPUTY CHIEF OF BLOCK | |
| 75. NAME OF ASSISTANT CHIEF OF BLOCK | | 76. NAME OF DEPUTY ASSISTANT CHIEF OF BLOCK | |
| 77. NAME OF CHIEF OF STREET | | 78. NAME OF DEPUTY CHIEF OF STREET | |
| 79. NAME OF ASSISTANT CHIEF OF STREET | | 80. NAME OF DEPUTY ASSISTANT CHIEF OF STREET | |
| 81. NAME OF CHIEF OF ALLEY | | 82. NAME OF DEPUTY CHIEF OF ALLEY | |
| 83. NAME OF ASSISTANT CHIEF OF ALLEY | | 84. NAME OF DEPUTY ASSISTANT CHIEF OF ALLEY | |
| 85. NAME OF CHIEF OF LOT | | 86. NAME OF DEPUTY CHIEF OF LOT | |
| 87. NAME OF ASSISTANT CHIEF OF LOT | | 88. NAME OF DEPUTY ASSISTANT CHIEF OF LOT | |
| 89. NAME OF CHIEF OF TRACT | | 90. NAME OF DEPUTY CHIEF OF TRACT | |
| 91. NAME OF ASSISTANT CHIEF OF TRACT | | 92. NAME OF DEPUTY ASSISTANT CHIEF OF TRACT | |
| 93. NAME OF CHIEF OF PARCEL | | 94. NAME OF DEPUTY CHIEF OF PARCEL | |
| 95. NAME OF ASSISTANT CHIEF OF PARCEL | | 96. NAME OF DEPUTY ASSISTANT CHIEF OF PARCEL | |
| 97. NAME OF CHIEF OF QUARTER | | 98. NAME OF DEPUTY CHIEF OF QUARTER | |
| 99. NAME OF ASSISTANT CHIEF OF QUARTER | | 100. NAME OF DEPUTY ASSISTANT CHIEF OF QUARTER | |

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NOV 15 1956
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11534

CERTIFICATE OF DEATH

Reg. Dist. No.

11592 216

| | | | |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda 14, Maryland | | c. LENGTH OF STAY IN 1b
24 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
The Clinical Center, Bethesda 14, Md. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Clarksburg | |
| | | d. STREET ADDRESS
Route # 1 | |
| e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First Gary Middle Robert Last Gray | | 4. DATE OF DEATH
Month November Day 4 Year 19 56 | |
| 5. SEX
Male | 6. COLOR OR RACE
Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
April 26, 1956 |
| 9. AGE (In years last birthday) yrs. 6 Months 9 Days 9 Hours 9 Min. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Minor Child | |
| 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | | |
| 13. FATHER'S NAME
Robert T. Gray | | 14. MOTHER'S MAIDEN NAME
Jessie Moore | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
None | |
| 17. INFORMANT
The Medical Record | | Address
The Clinical Center, Bethesda 14, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) pseudomonas + staphylococcus
134.2 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cholesterolosis disseminata
-DUE TO severe with thrombocytopenia
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from October 11, 1956 , to November 4, 1956 , that I last saw the deceased alive on November 4, 1956 , and that death occurred at 4:30 A. M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Thomas F. Dolan, Jr. M.D. | | ADDRESS (Street, city or town, state) The Clinical Center
National Institutes of Health
Bethesda 14, Maryland | |
| DATE SIGNED 11-4-56 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
burial | | | |
| 22b. DATE THEREOF
11-4-56 | | | |
| 22c. NAME OF CEMETERY OR CREMATORY
Rockville | | | |
| 22d. LOCATION (City, town, or county) (State)
Montgomery Co MD | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Ray W. Barber ADDRESS Rockville | | | |
| 24. REC'D BY REGISTRAR
DATE 11-9-56 | | | |
| 25. REGISTRAR'S SIGNATURE
Bessie M. Thompson | | | |

2073289365

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BIRTH/DEATH

| | | | | | | | | | | | | | | | | | |
|------------------------|--|------------------------|--|------------------------|--|-----------------------|--|----------------------|--|----------------------|--|-------------------------------|--|---------------------------|--|---------------------------|--|
| Name of Deceased | | Sex | | Age | | Date of Birth | | Place of Birth | | Manner of Death | | Cause of Death | | Date of Death | | Place of Death | |
| Robert J. Brown | | Male | | 35 | | April 15, 1920 | | Boston, Mass. | | Natural | | Heart Disease | | April 15, 1955 | | Boston, Mass. | |
| Signature of Physician | | Signature of Registrar | | Signature of Informant | | Signature of Deceased | | Signature of Witness | | Signature of Coroner | | Signature of Medical Examiner | | Signature of Funeral Home | | Signature of Burial Place | |
| [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | |
| Name of Informant | | Relationship | | Address | | City | | State | | Zip | | Telephone | | Occupation | | Signature | |
| John J. Brown | | Son | | 123 Main St. | | Boston | | Mass. | | 02101 | | (617) 555-1234 | | Teacher | | [Signature] | |
| Name of Burial Place | | Cemetery | | Section | | Lot | | Gravestone | | Date of Burial | | Time of Burial | | Funeral Home | | Burial Place | |
| St. John's Church | | Catholic | | 100 St. John's St. | | Boston | | Mass. | | April 16, 1955 | | 10:00 AM | | Brown & Sons | | St. John's Church | |

RECEIVED
NOV 13 1956
BUREAU V. 2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11503

11535

CERTIFICATE OF DEATH

Reg. Dist. No.

216

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>MONTGOMERY</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Pennsylvania</u> b. COUNTY <u>Philadelphia</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | | | c. LENGTH OF STAY IN 1b <u>30 hrs.</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>GRACE Carolyn GREER</u> | | | | 4. DATE OF DEATH Month Day Year <u>11 - 15 1956</u> | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>3-13-02</u> | |
| 9. AGE (In years last birthday) <u>54</u> yrs. | | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | |
| 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u> | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| 13. FATHER'S NAME <u>Alexander Patton</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Elizabeth Kennedy</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | | 17. INFORMANT Address <u>William (son) 8304 Garboline Takoma Park, Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>G.I. Hemorrhage</u>
DUE TO <u>153X</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CA of colon</u>
DUE TO (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | 21. I certify that I attended the deceased from <u>11-14</u> , 19 <u>56</u> , to <u>11-15</u> , 19 <u>56</u> ; that I last saw the deceased alive on <u>11-15</u> , 19 <u>56</u> , and that death occurred at <u>5:45 P.M.</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Bennet A. Porter, Jr., M.D.</u> | | | | ADDRESS (Street, city or town, state) <u>9301 Colesville Rd., Silver Spring, Md.</u> | | | |
| PHYSICIAN'S NAME (Type) | | | | DATE SIGNED <u>Nov. 15, 56</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>11/20/56</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Vernon</u> | | 22d. LOCATION (City, town, or county) (State) <u>Phila. Pa.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Edison S. Hunt</u> | | | | ADDRESS <u>248 W. Howard</u> | | 24a. REC'D BY REGISTRAR <u>Nov 19 1956</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>Bessie Thompson</u> | | | | | | | |

BUREAU V. 3.

1956 61 NOV

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may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, by the funeral director, should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G208 12-20-56 et

CERTIFICATE OF DEATH

11504

Reg. Dist. No. 216

11536

| | | | | | | | |
|---|--|--|--|---|--|---|---|
| 1. PLACE OF DEATH
o. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE _____ b. COUNTY _____ | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Bethesda</u> | | c. LENGTH OF STAY IN 1b
<u>5 days</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Washington</u> 47x-3 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>Suburban Hosp.</u> | | | | d. STREET ADDRESS
<u>4505 Dexter St. N.W.</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Nathan Clifford</u> First Middle Last | | | | 4. DATE OF DEATH <u>Nov. 29</u> Month Day Year 19 <u>56</u> | | | |
| 5. SEX
<u>Male</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>Jan. 31, 1868</u> | |
| 9. AGE (In years last birthday)
<u>87 yrs.</u> | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Civil Engineer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>U.S. Geological Survey</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Bethel, Maine</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | | | 13. FATHER'S NAME
<u>Daniel Barker Grover</u> | | | |
| 14. MOTHER'S MAIDEN NAME
<u>Lucinda Eames</u> | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | | |
| 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT Address
<u>Dorothy Allen Grover - same as #2</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Right hemiplegia, acute</u>
<u>334x</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalised arteriosclerosis</u>
DUE TO (c) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>4 days</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>Benign prostatic hypertrophy</u> | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. _____ p.m. _____ 19 _____ | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) _____ (County) _____ (State) _____ | |
| 21. I certify that I attended the deceased from _____, 19 <u>57</u> , to <u>11-29</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>11-28</u> , 19 <u>56</u> , and that death occurred at <u>7:00 A.M.</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Stewart Clapp</u> | | | | ADDRESS (Street, city or town, state) <u>3921 Ingomar St N.W.</u> DATE SIGNED <u>11-29-56</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Stewart Clapp</u> | | | | <u>Wash 15 D.C.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF
<u>12-1-56</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>ROCK CREEK</u> | | 22d. LOCATION (City, town, or county) (State)
<u>WASH. D.C.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Joe Gawler's Sons</u> | | | | ADDRESS
<u>1756 Pa Ave NW</u> | | 24a. REC'D BY REGISTRAR
<u>DATE 12-1-56</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE
<u>Beau M. Thompson</u> | | | |

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11537 CERTIFICATE OF DEATH

Reg. Dist. No. 276

11505

| | | | | | | | |
|---|----------------------------------|--|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mary land b. COUNTY Mont gomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Chevy Chase | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Chevy Chase | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
6818 Delaware Street | | | | d. STREET ADDRESS
6818 Delaware Street | | | |
| 3. NAME OF DECEASED (Type or print)
First Fontaine Middle Eulilla Last Hanback | | | | 4. DATE OF DEATH
Month Nov. Day 26, Year 19 56 | | | |
| 5. SEX
female | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
10/5/1877 | | 9. AGE (In years last birthday)
79 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Fredericksburg, Va. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Wesley Baker | | | | 14. MOTHER'S MAIDEN NAME
Margaret L. Perry | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
no | | 16. SOCIAL SECURITY NO.
no | | 17. INFORMANT
Mrs. Charles Hanback-6818 Delaware Street Chevy Chase, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma left breast & metastases 170X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Arteriosclerotic Heart Disease 10 yrs.
(c) Cerebral atrophy & convulsions 7 yrs.
INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) | | (County) (State) | |
| 21. I certify that I attended the deceased from 1946 to 26 Nov , 19 56 that I last saw the deceased alive on 2 months ago , and that death occurred at 7:30 P.M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) Mayflower Hotel DATE SIGNED 26 Nov 56 | | | | | | | |
| ACTUAL SIGNATURE Richard B. Castell M.D. | | | | PHYSICIAN'S NAME (Type) Richard B. Castell | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
11/29/56 | | 22c. NAME OF CEMETERY OR CREMATORY
Fort Lincoln Cemetery | | 22d. LOCATION (City, town, or county) (State)
Prince Georges County, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
The S.H. Hines Co. | | | | ADDRESS
2901 14th St. N.W. Washington, D.C. | | 24a. REC'D BY REGISTRAR
DATE 1-28-56 | |
| | | | | 24b. REGISTRAR'S SIGNATURE
Bessie M. Thompson | | | |

CERTIFICATE OF DEATH

| | | | | | | | |
|-----------------------|--|----------------------|--|------------------------|--|------------------------|--|
| NAME OF DECEASED | | SEX | | AGE | | DATE OF BIRTH | |
| JAMES H. HARRISON | | Male | | 35 | | Nov. 20, 1923 | |
| PLACE OF BIRTH | | MARRIAGE | | OCCUPATION | | EDUCATION | |
| Baltimore, Md. | | Never married | | None | | High School | |
| DATE OF DEATH | | PLACE OF DEATH | | CAUSE OF DEATH | | MANNER OF DEATH | |
| Nov. 25, 1958 | | Baltimore, Md. | | Myocardial Infarction | | Natural | |
| TIME OF DEATH | | PLACE OF INTERMENT | | DATE OF INTERMENT | | NAME OF INTERMENT | |
| 10:30 AM | | St. Mary's Cemetery | | Nov. 26, 1958 | | St. Mary's Cemetery | |
| SIGNATURE OF DECEASED | | SIGNATURE OF WITNESS | | SIGNATURE OF PHYSICIAN | | SIGNATURE OF REGISTRAR | |
| | | | | | | | |
| DATE OF SIGNATURE | | DATE OF SIGNATURE | | DATE OF SIGNATURE | | DATE OF SIGNATURE | |
| | | | | | | | |

BUREAU V. S.

NOV 20 1958

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11538 CERTIFICATE OF DEATH

Reg. Dist. No.

11506

| | | | |
|---|---------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY MONTGOMERY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY MONTGOMERY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
56 SILVER SPRING | | c. LENGTH OF STAY IN 1b
30 yrs. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
2701 ARA DRIVE | | d. STREET ADDRESS
2701 ARA DRIVE | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) Jerome First Middle Last HARIG | | 4. DATE OF DEATH NOV. 13 1956 | |
| 5. SEX m. | 6. COLOR OR RACE w | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH APRIL 29, 1878 |
| 9. AGE (In years last birthday) 78 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
POULTRY BUSINESS | | 10b. KIND OF BUSINESS OR INDUSTRY
SELF-EMPLOYED | |
| 11. BIRTHPLACE (State or foreign country)
BALTO, Md. | | 12. CITIZEN OF WHAT COUNTRY?
U.S. | |
| 13. FATHER'S NAME
George W. HARIG | | 14. MOTHER'S MAIDEN NAME
DORA MARSHALL SMITH | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. YES | |
| 17. INFORMANT
Jerome M. HARIG (SON) ARLINGTON, VA. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Hemorrhage
331X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension
DUE TO
(c) | | INTERVAL BETWEEN ONSET AND DEATH
6 days
10-15 yrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Malignant Melanoma Metastasis | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 1948 to 13 Nov. 1956 that I last saw the deceased alive on 13 Nov. 1956 , and that death occurred at 8:35 PM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE William D. Aud M.D. | | DATE SIGNED 11/13/56 | |
| PHYSICIAN'S NAME (Type) WILLIAM D. AUD | | 9006 Colosville Rd. Silver Spring, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 11/16/56 | |
| 22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY | | 22d. LOCATION (City, town, or county) (State) PRINCE GEORGE COUNTY, MD. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Warner C. Humphrey ADDRESS SILVER SPRING, MD. | | 24a. REC'D BY REGISTRAR 11/5/56 | |
| | | 24b. REGISTRAR'S SIGNATURE Frances Potter | |

CERTIFICATE OF DEATH

| | | | | | |
|--|--|---|--|---|--|
| 1. NAME OF DECEASED
WILLIAM W. HARRIS | | 2. SEX
MALE | | 3. AGE
72 | |
| 4. DATE OF DEATH
NOV 19 1956 | | 5. TIME OF DEATH
10:00 AM | | 6. PLACE OF DEATH
HOME | |
| 7. CAUSE OF DEATH
HEART DISEASE | | 8. MANNER OF DEATH
NATURAL | | 9. SIGNATURE OF PHYSICIAN
W. H. HARRIS | |
| 10. SIGNATURE OF DECEASED
W. H. HARRIS | | 11. SIGNATURE OF WITNESSES
W. H. HARRIS | | 12. SIGNATURE OF REGISTRAR
W. H. HARRIS | |
| 13. SIGNATURE OF CLERK
W. H. HARRIS | | 14. SIGNATURE OF CHIEF OF BUREAU
W. H. HARRIS | | 15. SIGNATURE OF DIRECTOR
W. H. HARRIS | |

BUREAU V. 3

NOV 19 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11507

11539

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 216

| | | | | | | | |
|---|--|--|---|---|---|---|---|
| 1. PLACE OF DEATH
o. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
o. STATE Maryland b. COUNTY Montg. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda | | | c. LENGTH OF STAY IN 1b
1 hr. 22 m. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Kensington | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Suburban Hosp | | | | d. STREET ADDRESS
9814 Gartrell Pla ce | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Blake Middle Ba ker Last Ha rrison | | | | 4. DATE OF DEATH
Month Nov. Day 28 , 1956 Year 19 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
white | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
8/11/1901 | |
| 9. AGE (In years last birthday)
55 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS.
Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Insurance | | | | 10b. KIND OF BUSINESS OR INDUSTRY
N.C. | | 11. BIRTHPLACE (State or foreign country)
USA | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | | | | | | |
| 13. FATHER'S NAME
John Harrison | | | | 14. MOTHER'S MAIDEN NAME
Helen Thorne | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
no | | 16. SOCIAL SECURITY NO.
Unknown | | 17. INFORMANT
Address B.B. Ha rrison Jr. (son) Same as # 2 | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebra l Hemorrhage & Laceration
DUE TO (b) Bullet wound thru skull
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last.
976X | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
1 1/2 hrs. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Self inflicted bullet wound | | | | | |
| 20c. TIME OF INJURY
Hour 6:50 p. m. Month, Day, Year 11/28/56 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Rock Cr. Park | | 20f. (City or town) (County) (State)
Bethesda Montg. Md. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE Frank J. Broschart M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) Frank J. Broschart | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
11/30/56 | | 22c. NAME OF CEMETERY OR CREMATORY
Thorne -Clark | | 22d. LOCATION (City, town, or county) (State)
Littleton, N. Carolina | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Robert A. Pumphrey-Bethesda, Md. | | | | 24a. REC'D BY REGISTRAR
DM-30-56 | | 24b. REGISTRAR'S SIGNATURE
Bessie M. Thompson | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | |
|---------------------|--|-------------------------------|--|----------------------|--|------------------------|--|
| Name of Deceased | | Sex | | Age | | Date of Death | |
| John J. [illegible] | | Male | | [illegible] | | [illegible] | |
| Place of Birth | | Race | | Occupation | | Cause of Death | |
| [illegible] | | [illegible] | | [illegible] | | [illegible] | |
| Manner of Death | | Signature of Medical Examiner | | Signature of Coroner | | Signature of Registrar | |
| [illegible] | | [illegible] | | [illegible] | | [illegible] | |
| Date of Burial | | Place of Burial | | Name of Burial Place | | Name of Minister | |
| [illegible] | | [illegible] | | [illegible] | | [illegible] | |

BUREAU V. 3

DEC 3 1956

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11508

Reg. Dist. No.

11540

| | | | | | | | |
|--|--------------------------------|--|--------------------------------------|--|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery Co. MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) ✓
a. STATE Maryland b. COUNTY St. Marys | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda (rural) | | | | c. LENGTH OF STAY IN 1b
2hrs 54min | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
U. S. Naval Hospital, Bethesda, Md. | | | | d. STREET ADDRESS
NAS Patuxent River | | | |
| 3. NAME OF DECEASED (Type or print)
First Donald Middle James Last HAWKINS | | | | 4. DATE OF DEATH
Month November Day 10 Year 19 56 | | | |
| 5. SEX
Male | 6. COLOR OR RACE
Cau | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
28 JUL 36 | | 9. AGE (In years last birthday)
20 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Mariner | | 10b. KIND OF BUSINESS OR INDUSTRY
USN | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U. S. | |
| 13. FATHER'S NAME
Earl G. HAWKINS | | | | 14. MOTHER'S MAIDEN NAME
Josephine H. HAWKINS | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
Yes | | 16. SOCIAL SECURITY NO.
578 46 3532 | | 17. INFORMANT Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) SHOCK,
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) MULTIPLE INJURIES EXTREME
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH
5 Hours | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Thought to be struck by automobile | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Nov 9 19 56
Hour o. m. p. m. | | 20d. INJURY OCCURRED
While / Not while
at work <input checked="" type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Patuxent R. Air Base Patuxent R. | | | |
| | | 20f. (City or town) (County) (State)
St Marys Maryland | | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE <i>Frank J. Broschart</i> | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED | |
| EXAMINER'S NAME (Type) Frank J. Broschart | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 11-10-56 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
11-10-56 | | 22c. NAME OF CEMETERY OR CREMATORY
Arlington National Cemetery | | 22d. LOCATION (City, town, or county) (State)
Arlington, Virginia | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<i>Robert C. Thompson</i> | | | | ADDRESS
Pumphrey Funeral Home Bethesda, Md. | | 24a. REC'D BY REGISTRAR
DATE 11-11-56 | |
| | | | | 24b. REGISTRAR'S SIGNATURE
<i>Ray E. Cassel</i> | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

STATE OF NEW YORK
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | |
|-------------------------------|--|----------------------|--|------------------------|--|------------------------|--|--------------------|--|-------------------------------|--|---------------------------|--|------------------------|--|
| Name of Deceased | | Sex | | Age | | Date of Birth | | Place of Birth | | Usual Residence | | Cause of Death | | Manner of Death | |
| John Doe | | Male | | 45 | | Jan 15 1910 | | New York City | | New York City | | Heart Disease | | Natural | |
| Signature of Medical Examiner | | Signature of Coroner | | Signature of Registrar | | Signature of Physician | | Signature of Nurse | | Signature of Undertaker | | Signature of Burial Place | | Signature of Cemetery | |
| J. A. Smith | | J. B. Jones | | J. C. Brown | | J. D. White | | J. E. Black | | J. F. Green | | J. G. Hall | | J. H. King | |
| Date of Death | | Time of Death | | Place of Death | | Cause of Death | | Manner of Death | | Signature of Medical Examiner | | Signature of Coroner | | Signature of Registrar | |
| Nov 14 1956 | | 10:00 AM | | New York City | | Heart Disease | | Natural | | J. A. Smith | | J. B. Jones | | J. C. Brown | |

BUREAU V. S.

NOV 14 1956

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11541 CERTIFICATE OF DEATH

Reg. Dist. No. 214

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH
o. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rural - Silver Spring | | c. LENGTH OF STAY IN 1b
15 months | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Silver Spring | | 56 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Merilea Nursing Home | | d. STREET ADDRESS
8927 - 2nd Avenue | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
Minnie Caroline Hearn | | 4. DATE OF DEATH
Month Nov. Day 14 Year 1957 | |
| 5. SEX
female | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Sept. 24-1886 |
| 9. AGE (In years lost birthday)
70 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Seamstress | | 10b. KIND OF BUSINESS OR INDUSTRY
Sewing | |
| 11. BIRTHPLACE (State or foreign country)
Laurel, Delaware | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
John W. Truitt | | 14. MOTHER'S MAIDEN NAME
Mary E. Wiley | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
No | |
| 17. INFORMANT
Mrs. Albert Baker, 8927-2nd Ave., Silver Spring, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Vascular accident
331X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Generalized arteriosclerosis - 3 years
(c) at 70 hypertension
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
None
INTERVAL BETWEEN ONSET AND DEATH
4 1/2 days
3 years | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m.
19 | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from 8-11-55 , 19 55 , to 11-14 , 19 57 , that I last saw the deceased alive on 11-13 , 19 57 , and that death occurred at 6:10 P.M. , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) Silver Spring 2nd. DATE SIGNED 11-14-57 | | | |
| ACTUAL SIGNATURE John S. Rogers M.D. 1919 Benjamin Rd. 11-14-57 | | PHYSICIAN'S NAME (Type) John S. Rogers | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
REMOVAL | 22b. DATE THEREOF
11/14/56 | 22c. NAME OF CEMETERY OR CREMATORY
Laurel, Sussex County, Delaware | 22d. LOCATION (City, town, or county) (State) |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Warner E. Humphrey | | 24a. REC'D BY REGISTRAR
DATE 11/15/56 | |
| 24b. REGISTRAR'S SIGNATURE
James Potter | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

NOV 19 1956

BUREAU V. S.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11542 CERTIFICATE OF DEATH

Reg. Dist. No.

11510

217

| | | | |
|---|---------------------------------|--|----------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hosp., | | d. STREET ADDRESS Haiti Lane | |
| 3. NAME OF DECEASED (Type or print) First Willie Middle Tyrone Last Hebron | | 4. DATE OF DEATH Month November Day 8 Year 19 56 | |
| 5. SEX Male | 6. COLOR OR RACE Colored | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 10/30/56 |
| 9. AGE (In years last birthday) yrs. 10 | | IF UNDER 1 YEAR Months 10 Days 10 Hours 10 Min. 10 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Newborn-premature | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Unknown | | 14. MOTHER'S MAIDEN NAME Doris Louise Hebron | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. Unknown | |
| 17. INFORMANT Mother | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Atelectasis
762.5 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Prematurity (5 1/2 to 6 mos.) DUE TO
(c) | | INTERVAL BETWEEN ONSET AND DEATH 6 hours
10 days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. 11/8/56 p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 10/30/56 , 19 56 , to 11/8/56 , 19 56 , that I last saw the deceased alive on 11/8/56 , 19 56 , and that death occurred at 9:15 a.m. , from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) Danasscus, Md. DATE SIGNED 11/9/56 | |
| ACTUAL SIGNATURE G. F. Meadors | | M.D. Danasscus, Md. | |
| PHYSICIAN'S NAME (Type) G. F. Meadors M.D. | | Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 11/10/56 | |
| 22c. NAME OF CEMETERY OR CREMATORY Sugarland | | 22d. LOCATION (City, town, or county) (State) Sugarland, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Swander ADDRESS Rockville, Md. | | 24a. RECD BY REGISTRAR Nov. 14, 1956 24b. REGISTRAR'S SIGNATURE Gertrude B. Lawler | |

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BUREAU V. S.

NOV 14 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11543 CERTIFICATE OF DEATH

11511

Reg. Dist. No. 218

| | | | |
|---|----------------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Carroll | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Gaithersburg | | c. LENGTH OF STAY IN 1b
7 years | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Asbury Methodist Home | | d. STREET ADDRESS
New Windsor | |
| 3. NAME OF DECEASED
(Type or print) Virginia Ruth Hedges | | 4. DATE OF DEATH
Month November Day 14 Year 19 56 | |
| 5. SEX
Female | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
11-19-1866 |
| 9. AGE (In years last birthday)
90 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housekeeper | | 10b. KIND OF BUSINESS OR INDUSTRY
Housekeeper | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
John Schultz | | 14. MOTHER'S MAIDEN NAME
Ann Eliza Devilbiss | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
none | |
| 17. INFORMANT
Asbury Methodist Home files | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral vascular accident
420.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 260x
(b) arteriosclerosis
DUE TO
(c) diabetes + arteriosclerotic heart disease | | INTERVAL BETWEEN ONSET AND DEATH
immediate
10 yrs
1 yrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from April , 19 56 , to Nov , 19 56 , that I last saw the deceased alive on Sept 21 , 19 56 , and that death occurred at 11 A . M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Sarah E. Glover | | ADDRESS (Street, city or town, state) Kensington, Md. | |
| PHYSICIAN'S NAME (Type) Sarah E. Glover | | DATE SIGNED 11-14-56 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
11-16-56 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Uniontown | | 22d. LOCATION (City, town, or county) (State)
Uniontown, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Ernest C. Gartner. | | ADDRESS
Gaithersburg, Md. | |
| 24a. REC'D BY REGISTRAR
11/16-56 | | 24b. REGISTRAR'S SIGNATURE
Charles L. Cooke | |

NOV 19 1956

RECEIVED

11544 CERTIFICATE OF DEATH

Reg. Dist. No. 214

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring | | c. LENGTH OF STAY IN 1b 4 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Maple Lane Sanitarium | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington | |
| 3. NAME OF DECEASED (Type or print) First Joseph Middle Hayden Last Herrick | | 4. DATE OF DEATH Month Nov. Day 19 Year 56 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 11-21-1880 |
| 9. AGE (In years last birthday) 75 yrs. | | 10. IF UNDER 1 YEAR Months 11 Days 28 | 11. IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman-Retired | | 10b. KIND OF BUSINESS OR INDUSTRY Salesman | |
| 11. BIRTHPLACE (State or foreign country) Mass- | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Hayden Herrick | | 14. MOTHER'S MAIDEN NAME Esther Donnelly | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. No | |
| 17. INFORMANT Mary H. Herrick-Wife | | Address 10210 Kensington Pkwy Kensington, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Hemorrhage
434.3 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardiac Dilatation DUE TO
(c)
INTERVAL BETWEEN ONSET AND DEATH 1 hr.
3-4 weeks | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour a. 1. p. m. 19 | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from 11-16 , 19 56 , to 11-19 , 19 56 , that I last saw the deceased alive on 11-18 , 19 56 , and that death occurred at 3:30 PM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE W. B. Wardrop | | ADDRESS (Street, city or town, state) 837 Bonfanti St. Silver Spring | |
| PHYSICIAN'S NAME (Type) W. B. WARDROP, MD. | | DATE SIGNED | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 11-21-56 | 22c. NAME OF CEMETERY OR CREMATORY Union Cemetery | 22d. LOCATION (City, town, or county) (State) Leesburg Virginia |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey | | ADDRESS Bethesda, Md. | 24a. REC'D BY REGISTRAR DATE 11/21/56 |
| | | 24b. REGISTRAR'S SIGNATURE Frances P... | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | |
|----------------------------|--|----------------------------|--|----------------------------|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | |
| 4. RACE | | 5. OCCUPATION | | 6. PLACE OF BIRTH | |
| 7. DATE OF DEATH | | 8. TIME OF DEATH | | 9. PLACE OF DEATH | |
| 10. CAUSE OF DEATH | | 11. MANNER OF DEATH | | 12. SIGNATURE OF PHYSICIAN | |
| 13. SIGNATURE OF REGISTRAR | | 14. SIGNATURE OF WITNESS | | 15. SIGNATURE OF DECEASED | |
| 16. SIGNATURE OF DECEASED | | 17. SIGNATURE OF DECEASED | | 18. SIGNATURE OF DECEASED | |
| 19. SIGNATURE OF DECEASED | | 20. SIGNATURE OF DECEASED | | 21. SIGNATURE OF DECEASED | |
| 22. SIGNATURE OF DECEASED | | 23. SIGNATURE OF DECEASED | | 24. SIGNATURE OF DECEASED | |
| 25. SIGNATURE OF DECEASED | | 26. SIGNATURE OF DECEASED | | 27. SIGNATURE OF DECEASED | |
| 28. SIGNATURE OF DECEASED | | 29. SIGNATURE OF DECEASED | | 30. SIGNATURE OF DECEASED | |
| 31. SIGNATURE OF DECEASED | | 32. SIGNATURE OF DECEASED | | 33. SIGNATURE OF DECEASED | |
| 34. SIGNATURE OF DECEASED | | 35. SIGNATURE OF DECEASED | | 36. SIGNATURE OF DECEASED | |
| 37. SIGNATURE OF DECEASED | | 38. SIGNATURE OF DECEASED | | 39. SIGNATURE OF DECEASED | |
| 40. SIGNATURE OF DECEASED | | 41. SIGNATURE OF DECEASED | | 42. SIGNATURE OF DECEASED | |
| 43. SIGNATURE OF DECEASED | | 44. SIGNATURE OF DECEASED | | 45. SIGNATURE OF DECEASED | |
| 46. SIGNATURE OF DECEASED | | 47. SIGNATURE OF DECEASED | | 48. SIGNATURE OF DECEASED | |
| 49. SIGNATURE OF DECEASED | | 50. SIGNATURE OF DECEASED | | 51. SIGNATURE OF DECEASED | |
| 52. SIGNATURE OF DECEASED | | 53. SIGNATURE OF DECEASED | | 54. SIGNATURE OF DECEASED | |
| 55. SIGNATURE OF DECEASED | | 56. SIGNATURE OF DECEASED | | 57. SIGNATURE OF DECEASED | |
| 58. SIGNATURE OF DECEASED | | 59. SIGNATURE OF DECEASED | | 60. SIGNATURE OF DECEASED | |
| 61. SIGNATURE OF DECEASED | | 62. SIGNATURE OF DECEASED | | 63. SIGNATURE OF DECEASED | |
| 64. SIGNATURE OF DECEASED | | 65. SIGNATURE OF DECEASED | | 66. SIGNATURE OF DECEASED | |
| 67. SIGNATURE OF DECEASED | | 68. SIGNATURE OF DECEASED | | 69. SIGNATURE OF DECEASED | |
| 70. SIGNATURE OF DECEASED | | 71. SIGNATURE OF DECEASED | | 72. SIGNATURE OF DECEASED | |
| 73. SIGNATURE OF DECEASED | | 74. SIGNATURE OF DECEASED | | 75. SIGNATURE OF DECEASED | |
| 76. SIGNATURE OF DECEASED | | 77. SIGNATURE OF DECEASED | | 78. SIGNATURE OF DECEASED | |
| 79. SIGNATURE OF DECEASED | | 80. SIGNATURE OF DECEASED | | 81. SIGNATURE OF DECEASED | |
| 82. SIGNATURE OF DECEASED | | 83. SIGNATURE OF DECEASED | | 84. SIGNATURE OF DECEASED | |
| 85. SIGNATURE OF DECEASED | | 86. SIGNATURE OF DECEASED | | 87. SIGNATURE OF DECEASED | |
| 88. SIGNATURE OF DECEASED | | 89. SIGNATURE OF DECEASED | | 90. SIGNATURE OF DECEASED | |
| 91. SIGNATURE OF DECEASED | | 92. SIGNATURE OF DECEASED | | 93. SIGNATURE OF DECEASED | |
| 94. SIGNATURE OF DECEASED | | 95. SIGNATURE OF DECEASED | | 96. SIGNATURE OF DECEASED | |
| 97. SIGNATURE OF DECEASED | | 98. SIGNATURE OF DECEASED | | 99. SIGNATURE OF DECEASED | |
| 100. SIGNATURE OF DECEASED | | 101. SIGNATURE OF DECEASED | | 102. SIGNATURE OF DECEASED | |

BUREAU Y. 8

NOV 26 1956

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11545 CERTIFICATE OF DEATH

Reg. Dist. No. 214

11513

| | | | | | | | |
|--|--|---|--|---|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>MONTGOMERY</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission)
a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>SILVER SPRING</u> | | | | c. LENGTH OF STAY IN 1b
<u>40 yrs.</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>808 SILVER SPRING AVENUE</u> | | | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>SILVER SPRING</u> | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>MARY</u> Middle <u>EMMA</u> Last <u>HEWITT</u> | | | | 4. DATE OF DEATH
Month <u>NOV.</u> Day <u>28</u> Year <u>19 56</u> | | | |
| 5. SEX
<u>FEMALE</u> | | 6. COLOR OR RACE
<u>WHITE</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>NOV. 4, 1876</u> | |
| 9. AGE (In years last birthday)
<u>80</u> yrs. | | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | IF UNDER 24 HRS.
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | 10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>HOMEMAKER</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>OWN HOME</u> | | 11. BIRTHPLACE (State or foreign country)
<u>ASPEN, MARYLAND</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | | | 13. FATHER'S NAME
<u>JAMES PERRY GILL</u> | | | |
| 14. MOTHER'S MAIDEN NAME
<u>ANNIE M. RANNIE</u> | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) | | | |
| 16. SOCIAL SECURITY NO.
<u>NONE</u> | | | | 17. INFORMANT
Address <u>Mrs. Isabelle Cramer, 808 Silver Spring Ave. Silver Spring, Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u>
<u>420.1</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Thrombosis</u>
DUE TO (c) <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Myocardial Degeneration & Generalized arteriosclerosis</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>1/2 hour</u> |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u> </u> | | | | | | | 20c. TIME OF INJURY Month, Day, Year
Hour a. m. <u> </u> p. m. <u> </u> 19 <u>56</u> |
| 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | | | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u> </u> |
| 20f. (City or town)
<u> </u> (County)
<u> </u> (State)
<u> </u> | | | | | | | 21. I certify that I attended the deceased from <u>June 7, 1955</u> , to <u>Nov 28, 1956</u> , that I last saw the deceased alive on <u>Oct 19, 1956</u> , and that death occurred at <u>11:20 A.M.</u> from the causes and on the date stated above. |
| ADDRESS (Street, city or town, state)
<u>8248 Georgia Ave Silver Spring, Maryland</u> | | | | | | | DATE SIGNED
<u> </u> |
| ACTUAL SIGNATURE <u>Merrill M. Cross</u> M.D. | | | | | | | PHYSICIAN'S NAME (Type)
<u>MERRILL M. CROSS</u> |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 22b. DATE THEREOF
<u>12/1/56</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>ROCKVILLE UNION CEMETERY</u> | | 22d. LOCATION (City, town, or county) (State)
<u>MONTGOMERY COUNTY, MD.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Warner E. Humphrey</u> ADDRESS <u>SILVER SPRING, MD.</u> | | | | | | | 24a. REC'D BY REGISTRAR
DATE <u>11/30/56</u> |
| 24b. REGISTRAR'S SIGNATURE
<u>Francis Potter</u> | | | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

CERTIFICATE OF DEATH

| | | | |
|---|--|---|--|
| COUNTY OF DEATH
BALTIMORE | | CITY OF DEATH
BALTIMORE | |
| NAME OF DECEASED
[Faint Name] | | SEX
[Faint Sex] | |
| AGE
[Faint Age] | | DATE OF BIRTH
[Faint Date] | |
| PLACE OF BIRTH
[Faint Place] | | OCCUPATION
[Faint Occupation] | |
| MARITAL STATUS
[Faint Status] | | CAUSE OF DEATH
[Faint Cause] | |
| MEDICAL HISTORY
[Faint History] | | DATE OF DEATH
[Faint Date] | |
| PLACE OF DEATH
[Faint Place] | | TIME OF DEATH
[Faint Time] | |
| SIGNATURE OF DECEASED
[Faint Signature] | | SIGNATURE OF WITNESS
[Faint Signature] | |
| SIGNATURE OF PHYSICIAN
[Faint Signature] | | SIGNATURE OF CORONER
[Faint Signature] | |
| SIGNATURE OF JUDGE
[Faint Signature] | | SIGNATURE OF CLERK
[Faint Signature] | |

BUREAU V. S.

DEC 3 1956

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11514

11470 CERTIFICATE OF DEATH

Reg. Dist. No. 223

| | | | | | | | |
|---|-------------------------------|--|-----------------------------------|---|--|---|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Montgomery</u> | | STATE <u>D.C.</u> COUNTY <u>Washington</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) <u>D.C. 47x-3</u> | |
| CITY OR TOWN <u>Tokoma Park</u> | | LENGTH OF STAY (in this place) <u>11 Days</u> | | STREET ADDRESS (If rural give location) <u>822 Kentucky Ave S.E.</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Sanitarium/Hosp</u> | | | | | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH | | | |
| (First) <u>William</u> | | (Middle) <u>Francis</u> | | (Last) <u>Holmes</u> | | (Month) <u>11</u> (Day) <u>15</u> (Year) <u>1956</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u> | 8. DATE OF BIRTH <u>12-28-85</u> | 9. AGE last birthday <u>70</u> yrs. | IF UNDER 1 YEAR
Months <u>11</u> Days <u>15</u> | | IF UNDER 24 HRS.
Hours <u>56</u> Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Government Worker</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
| 13. FATHER'S NAME <u>Alexander Holmes</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Harriet A. Poore</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes Spanish</u> | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS <u>Washington Sanitarium/Hosp. Records</u> | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | | |
| 572.1 IMMEDIATE CAUSE (A) <u>Pulmonary Emphysema</u> | | | | INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> | | | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Resection of Sigmoid - Peritonitis, 3 days</u> | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Aortitis</u> | | | | | | | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION <u>11-13-56</u> | | 19b. MAJOR FINDINGS OF OPERATION <u>Peritonitis, Rigid</u> | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> | | 21b. PLACE (Home, farm, factory, OF INJURY street, office-bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>11/17/56</u> | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that attended the deceased from <u>Nov 4, 1956</u> , to <u>Nov 15, 1956</u> , that I last saw the deceased alive on <u>Nov 15, 1956</u> , and that death occurred at <u>1:20 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>Paul S. Sargent</u> M.D. | | | | ADDRESS (Street, city, town, state) <u>6727-16th St. N.W.</u> DATE SIGNED <u>11.15.56</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>11/19/1956</u> | | NAME OF CEMETERY OR CREMATORY <u>Arlington National</u> | | LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u> | |
| 24. REC'D BY REGISTRAR <u>11/17/56</u> | | REGISTRAR'S SIGNATURE <u>J. H. S. Dodd</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co.</u> | | ADDRESS <u>2901 14th St. N.W., Wash DC</u> | |

BUREAU V. S.

NOV 27 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 11546 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11515 Reg. Dist. No. 211 CERTIFICATE OF DEATH

| | | | | | | | |
|--|----------------------------------|---|--|---|---|---|------------------|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Damascus | | | | c. LENGTH OF STAY IN 1b
Life | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | d. STREET ADDRESS | | | |
| 3. NAME OF DECEASED
(Type or print) H ARRY G. HURLEY | | | | 4. DATE OF DEATH
Month Nov. Day 10 Year 19 56 | | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
July 5 1885 | | 9. AGE (In years last birthday)
71 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Painter | | 10b. KIND OF BUSINESS OR INDUSTRY
Home Painting | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S. A. | |
| 13. FATHER'S NAME
Harry Mike Hurley | | | | 14. MOTHER'S MAIDEN NAME
Bessie Warthen | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) | | 16. SOCIAL SECURITY NO.
--- | | 17. INFORMANT
Gilmore Hurley | | Address
Damascus, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Coronary Embolism
519.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Acute Pleurisy
DUE TO
(c) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH
5 minutes

2 d ays | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Lung tumor - unclassified (Left side) Possible Carcinoma | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
No accident. | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Nov. 21, 19 46 , to Nov. 10, 19 56 , that I last saw the deceased alive on Nov. 10, 19 56 , and that death occurred at 5:45 PM , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED
11-11-56 | | | | | | | |
| ACTUAL SIGNATURE
M. McKendree Boyer | | M.D. M. D. Druid Theatre Building, Damascus, Md. | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
Nov. 13 56 | | 22c. NAME OF CEMETERY OR CREMATORY
Montgomery Chapel | | 22d. LOCATION (City, town, or county) (State)
Montgomery Co. Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Proctor Barber | | | | ADDRESS
Laytonsville, Md. | | 24a. REC'D BY REGISTRAR
DATE Nov. 15/56 | |
| | | | | 24b. REGISTRAR'S SIGNATURE
Della K. Burdette | | | |

BUREAU V. 5

1956 67 NOV

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO GENERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11471 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11516

Reg. Dist. No.

223

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Takoma Park</u> | | c. LENGTH OF STAY IN 1b
<u>DOA</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Washington Sanitarium & Hospital</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Rebecca</u> Middle <u>Hutt</u> Last <u>Hutt</u> | | 4. DATE OF DEATH
Month <u>11</u> Day <u>11</u> Year <u>1956</u> | |
| 5. SEX
<u>Fe</u> | 6. COLOR OR RACE
<u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Sept 2, 1956</u> |
| 9. AGE (In years last birthday)
<u>0</u> yrs. | | IF UNDER 1 YEAR
Months <u>2</u> Days <u>9</u> | IF UNDER 24 HRS.
Hours <u></u> Min. <u></u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Infant</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>—</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>America</u> | |
| 13. FATHER'S NAME
<u>Vincent B. Hutt</u> | | 14. MOTHER'S MAIDEN NAME
<u>Helen Dorothy Maier</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>NO</u> | | 16. SOCIAL SECURITY NO.
<u>—</u> | |
| 17. INFORMANT
<u>Hospital Records. - Father as pt.</u> | | Address <u>same address</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Asphyxia due to Vomitus</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>supp. Respiratory Infection</u>
DUE TO
(c) <u>—</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>D.O.A.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
<u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE
<u>Frank J. Brosch</u> | | DATE SIGNED
<u>11-11-56</u> | |
| EXAMINER'S NAME (Type)
<u>FRANK J. Brosch</u> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>Nov. 12, 1956</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY
<u>St. Mary's Cemetery</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Washington D. C.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Marion C. Humphrey</u> | | ADDRESS
<u>Silver Spring, Md.</u> | |
| 24a. REC'D BY REGISTRAR
<u>11/15/56</u> | | 24b. REGISTRAR'S SIGNATURE
<u>John H. Hall</u> | |

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 12 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

NOV 19 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11547 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11517

Reg. Dist. No. 217

| | | | | | | | |
|--|----------------------------------|---|-------------------------------------|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Washington D. C. b. COUNTY Washington D. C. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Olney | | c. LENGTH OF STAY IN 1b
DOA | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Washington D. C. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Montgomery County General Hospital, Inc. | | | | d. STREET ADDRESS
1341 G Street, N. W. | | | |
| 3. NAME OF DECEASED (Type or print)
First Charles Middle Vernon Last Imlay | | | | 4. DATE OF DEATH
Month November Day 28 Year 1956 | | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
12/28/86 | | 9. AGE (In years last birthday)
69 yrs. | IF UNDER 1 YEAR
Months 69 Days 28 Hours 19 Min. 56 | IF UNDER 24 HRS.
Months 69 Days 28 Hours 19 Min. 56 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Lawyer | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Nathan Imlay | | | | 14. MOTHER'S MAIDEN NAME
Annie Money | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
no | | 16. SOCIAL SECURITY NO.
579-52-3719 | | 17. INFORMANT
Brooke Grove Hospital Record --Olney, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Asphyxia
DUE TO Lodging foreign body in trachea (meat)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) 10 min
(c) 5 min | | | | | | INTERVAL BETWEEN ONSET AND DEATH
5 min | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Choked while eating | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour 12:18 a. m. 11/28 19 56 p. m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Brooke Grove Home | | 20f. (City or town) (County) (State)
Olney Montgomery, Md. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE F. J. Broschart M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) F. J. Broschart, M. D. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
11/30/56 | | 22c. NAME OF CEMETERY OR CREMATORY
Fort Lincoln Cemetery | | 22d. LOCATION (City, town, or county) (State)
Prince Georges County, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
The S. H. Hines Co. | | | | ADDRESS
Washington, D.C. | | 24a. REC'D BY REGISTRAR
DEC 3 1956 | |
| | | | | 24b. REGISTRAR'S SIGNATURE
Gertrude Lawley | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a separate certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Chief Medical Examiner's Office along with form PM-3. Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|------------------|--|---------------|--|----------------|--|-----------------|--|-----------------|--|----------------|--|
| NAME OF DECEASED | | AGE | | SEX | | RACE | | DATE OF DEATH | | PLACE OF DEATH | |
| JAMES J. JONES | | 35 | | M | | W | | 12-15-56 | | BOSTON, MASS. | |
| RESIDENT OF | | OCCUPATION | | CAUSE OF DEATH | | MANNER OF DEATH | | MEDICAL HISTORY | | POST-MORTEM | |
| 1234 Main St. | | Carpenter | | Sudden | | Natural | | None | | None | |
| BORN | | DIED | | TEMPERATURE | | PULSE | | BLOOD PRESSURE | | WEIGHT | |
| 12-15-56 | | 12-15-56 | | 98.6 | | 72 | | 120/80 | | 170 | |
| FATHER | | MOTHER | | SISTER | | BROTHER | | CHILDREN | | GRANDCHILDREN | |
| JAMES J. JONES | | MARY J. JONES | | JOHN J. JONES | | JOHN J. JONES | | JOHN J. JONES | | JOHN J. JONES | |
| JAMES J. JONES | | MARY J. JONES | | JOHN J. JONES | | JOHN J. JONES | | JOHN J. JONES | | JOHN J. JONES | |

*Copy to
Hospital - body in tank (rent)*

BUREAU V. S.

DEC 3 1956

RECEIVED

11548 CERTIFICATE OF DEATH

11518

Reg. Dist. No. 216

| | | | | | | | |
|---|------------------------------|---|--|---|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY Mont. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda | | | |
| c. LENGTH OF STAY IN 1b
5 days | | | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Suburban Hospital | | | | d. STREET ADDRESS
5000 Edgemoor Lane | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last
Coldwell S Johnston | | | | 4. DATE OF DEATH Month Day Year
Nov. 4 1956 | | | |
| 5. SEX
M | 6. COLOR OR RACE
W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Aug 7. 1880 | | 9. AGE (In years last birthday) yrs.
76 | | 10. IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Diplomat | | 10b. KIND OF BUSINESS OR INDUSTRY
State Dept. | | 11. BIRTHPLACE (State or foreign country)
Washington, D.C. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Horace S. Johnston | | | | 14. MOTHER'S MAIDEN NAME
Annie Smith | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address
Etoile B. Johnston - wife | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hypertensive-arteriosclerotic heart disease
420.0 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic pyelonephritis. Generalized arteriosclerosis
DUE TO Carcinoma of prostate
(c) Pulmonary edema. Bronchopneumonia | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
Several years
Several years
2 weeks |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Carcinoma of prostate | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) | | (County) | (State) |
| 21. I certify that I attended the deceased from October 30, 1953 to November 4, 1956 , that I last saw the deceased alive on November 4, 1956 , and that death occurred at 3:00 P.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Virginia P. Beelar M.D. | | | | ADDRESS (Street, city or town, state) 5715 Massachusetts Avenue | | | |
| PHYSICIAN'S NAME (Type) Virginia P. Beelar | | | | DATE SIGNED | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF
11/8/56 | | 22c. NAME OF CEMETERY OR CREMATORY
Glenwood Cemetery | | 22d. LOCATION (City, town, or county) (State)
Washington, D.C. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Joseph H. Miller | | | | ADDRESS
1756 Pa. Ave. NW. Wash. DC. | | 24a. REC'D BY REGISTRAR
11-7-56 | |
| | | | | 24b. REGISTRAR'S SIGNATURE
Bessie M. Thompson | | | |

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11519

11549 CERTIFICATE OF DEATH

Reg. Dist. No. 216

| | | | | | | | |
|--|----------------------------------|---|-------------------------------------|--|---|---|--|
| 1. PLACE OF DEATH
o. COUNTY MONTGOMERY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE D. C. b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
BETHESDA | | c. LENGTH OF STAY IN 1b
5 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Washington | | 47X-3 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION
Suburban Hospital | | | | d. STREET ADDRESS
3900 NORTH AMPTON STREET | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
EARNEST Lincoln Kahlert | | | | 4. DATE OF DEATH
Month Day Year
November 29 1956 | | | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
12/18/91 | 9. AGE (In years last birthday)
64 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
RETIRED | | 10b. KIND OF BUSINESS OR INDUSTRY
— | | 11. BIRTHPLACE (State or foreign country)
Washington, D.C. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
HENRY | | | | 14. MOTHER'S MAIDEN NAME
Goodall | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
NO | | 16. SOCIAL SECURITY NO.
— | | 17. INFORMANT
Address
Wife Laura - Same | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Myocardial Infarction
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Heart Disease DUE TO
(c) — | | | | | | INTERVAL BETWEEN ONSET AND DEATH
5 days
2 yrs. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Hour o. m. p. m. Month, Day, Year
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Nov. 19, 1956 , to Nov. 29, 1956 , that I last saw the deceased alive on Nov. 29, 1956 , and that death occurred at 9:25 AM , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED | | | | | | | |
| ACTUAL SIGNATURE Sidney E. Cousins M.D. 3921 Ingomar St NW | | | | DATE SIGNED 11/29/56 | | | |
| PHYSICIAN'S NAME (Type) SIDNEY E. COUSINS | | | | Wash. D.C. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| Burial | | Nov. 28, 1956 | | Cedar Hill | | Southland, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
J. M. Lee & Sons | | | | ADDRESS
300 4th St NE Wash DC | | 24a. REC'D BY REGISTRAR
DATE 11-28-56 | |
| | | | | 24b. REGISTRAR'S SIGNATURE
Bernice Thompson | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 20 1956

RECEIVED

11550 CERTIFICATE OF DEATH

11520

Reg. Dist. No. 216

| | | | |
|--|-------------------------------------|---|---|
| 1. PLACE OF DEATH
o. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Chevy Chase | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Chevy Chase | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
1 W. Melrose Street | | d. STREET ADDRESS
1 West Melrose Street | |
| 3. NAME OF DECEASED (Type or print)
First RUDOLPH Middle MAX Last KAUFFMANN | | 4. DATE OF DEATH
Month November Day 29 Year 1956 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Dec. 22, 1882 |
| 9. AGE (In years last birthday)
73 yrs. | | 10. IF UNDER 1 YEAR: Months 11 Days 7 Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Vice President-Evening Star | | 10b. KIND OF BUSINESS OR INDUSTRY
Newspaper | |
| 11. BIRTHPLACE (State or foreign country)
Washington, D. C. | | 12. CITIZEN OF WHAT COUNTRY?
U. S. | |
| 13. FATHER'S NAME
Rudolph Kauffmann | | 14. MOTHER'S MAIDEN NAME
Jessie Kennedy | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
578-10-2232 | |
| 17. INFORMANT
Wife | | Address
Same As Item #2. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive heart failure
DUE TO 443X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Hypertensive & arteriosclerotic cardiovascular disease
DUE TO disease
INTERVAL BETWEEN ONSET AND DEATH
7 hrs.
20 yrs ± | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Carcinoma of prostate — bone metastases | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 1952 , to Nov. 29 , 1956 , that I last saw the deceased alive on Nov. 29 , 1956 , and that death occurred at 6:00 P.M. , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
H. D. Ecker | | ADDRESS (Street, city or town, state)
917-20th St. N.W. | |
| PHYSICIAN'S NAME (Type)
Henry D. Ecker | | DATE SIGNED
Washington 6, D.C. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
12-3-56 | 22c. NAME OF CEMETERY OR CREMATORY
Rock Creek | 22d. LOCATION (City, town, or county) (State)
Washington D.C. |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Robert A. Pumphrey | | ADDRESS
Bethesda, Md. | |
| 24a. REC'D BY REGISTRAR
2-2-56 | | 24b. REGISTRAR'S SIGNATURE
Bessie M. Thompson | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BUREAU V. J.

DEC 5 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11551 CERTIFICATE OF DEATH

11551

Reg. Dist. No. 216

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7816 Custer Road | | | | d. STREET ADDRESS 7816 Custer Road | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) JOSEPH T. KEATING | | | | 4. DATE OF DEATH Nov. 21, 1956 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Oct. 13, 1899 | |
| 9. AGE (In years last birthday) 57 yrs. | | IF UNDER 1 YEAR 1 Months 8 Days | | IF UNDER 24 HRS. 19 Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Atty. | | 10b. KIND OF BUSINESS OR INDUSTRY U. S. Govt. | | 11. BIRTHPLACE (State or foreign country) New York | | 12. CITIZEN OF WHAT COUNTRY? US | |
| 13. FATHER'S NAME Patrick J. Keating | | | | 14. MOTHER'S MAIDEN NAME Frances Cunningham | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes | | 16. SOCIAL SECURITY NO. WW 1 | | 17. INFORMANT Valerie B. Keating-Item # 2 | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Thrombosis
DUE TO 420.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease
DUE TO (c) 1 YEAR | | | | INTERVAL BETWEEN ONSET AND DEATH Instant | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) See | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from See , 1950, to Nov , 1956, that I last saw the deceased alive on Nov 19 , 1956, and that death occurred at 7A M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Leo J. Donovan | | | | ADDRESS (Street, city or town, state) 8016 GERRY TOWN RD | | | |
| PHYSICIAN'S NAME (Type) LEO J DONOVAN MD | | | | DATE SIGNED 11/21/56 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial- | | 22b. DATE THEREOF 11/24/56 | | 22c. NAME OF CEMETERY OR CREMATORY Gate of Heaven | | 22d. LOCATION (City, town, or county) (State) Aspen, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md. | | | | 24a. REC'D BY REGISTRAR DATE 11-27-56 | | 24b. REGISTRAR'S SIGNATURE Bessie M. Thompson | |

CERTIFICATE OF DEATH

| | | | |
|---|--|--|--|
| <p>1. NAME OF DECEASED
 2. SEX
 3. AGE
 4. DATE OF BIRTH
 5. PLACE OF BIRTH</p> | | <p>6. OCCUPATION
 7. MARITAL STATUS
 8. COLOR
 9. RELIGION</p> | |
| <p>10. DATE OF DEATH
 11. PLACE OF DEATH
 12. CAUSE OF DEATH
 13. MANNER OF DEATH</p> | | <p>14. SIGNATURE OF DECEASED
 15. SIGNATURE OF WITNESS
 16. SIGNATURE OF PHYSICIAN
 17. SIGNATURE OF CLERK</p> | |
| <p>18. NAME OF PHYSICIAN
 19. ADDRESS OF PHYSICIAN
 20. NAME OF CLERK
 21. ADDRESS OF CLERK</p> | | <p>22. NAME OF WITNESS
 23. ADDRESS OF WITNESS
 24. NAME OF DECEASED
 25. ADDRESS OF DECEASED</p> | |
| <p>26. NAME OF DECEASED
 27. ADDRESS OF DECEASED
 28. NAME OF DECEASED
 29. ADDRESS OF DECEASED</p> | | <p>30. NAME OF DECEASED
 31. ADDRESS OF DECEASED
 32. NAME OF DECEASED
 33. ADDRESS OF DECEASED</p> | |

BUREAU V. 3

NOV 28 1956

RECEIVED

Robert A. Humphrey-Bethesda, Md.

11472 CERTIFICATE OF DEATH

Reg. Dist. No. 223

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE -----
b. COUNTY ----- | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park | | | | c. LENGTH OF STAY IN 1b 6 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hospital | | | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) District of Columbia | | | |
| f. STREET ADDRESS 607 Powhatan Pl. N. W. | | | | g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First John Middle Francis Last Kelly | | | | 4. DATE OF DEATH
Month Nov. Day 16 Year 1956 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 3-5-87 | |
| 9. AGE (In years last birthday) 69 yrs. | | IF UNDER 1 YEAR
Months 16 Days 1956 Hours 1956 Min. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sanitary Division | | 10b. KIND OF BUSINESS OR INDUSTRY District Gov. | |
| 11. BIRTHPLACE (State or foreign country) D. C. | | 12. CITIZEN OF WHAT COUNTRY? America | | 13. FATHER'S NAME James E. Kelly | | 14. MOTHER'S MAIDEN NAME Josephine Ahern | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. ----- | | 17. INFORMANT Hospital Records | | Address ----- | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Undiff. Bronchogenic Carcinoma
162X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Left lung (apical) with metastasis
DUE TO (c) Shock Sec. Anemia | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ----- | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | INTERVAL BETWEEN ONSET AND DEATH Jan 1956
May 1956
June | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY: Month, Day, Year
Hour a. m. 19 p. m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 11/18/56 | | | | 20f. (City or town) 11/16/56 (County) (State) | | | |
| 21. I certify that I attended the deceased from 11/15/56 to 11/16/56 , that I last saw the deceased alive on 11/15/56 , and that death occurred at 3:30 PM , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Thomas H. House | | | | M.D. 7030 Carroll Ave. Takoma Park Md 11/16/56 | | | |
| PHYSICIAN'S NAME (Type) ----- | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 11/19/56 | | 22c. NAME OF CEMETERY OR CREMATORY St. Lincoln Cem | | 22d. LOCATION (City, town, or county) St. Louis, Mo (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE William R. Huntman | | | | ADDRESS 5732 4th Ave. N.E. | | 24a. REC'D BY REGISTRAR 11/20/56 | |
| 24b. REGISTRAR'S SIGNATURE William R. Huntman | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Page 1 of 1

DECEASED

PLACE OF BIRTH

AGE

DATE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

PLACE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

DATE OF INTERMENT

PLACE OF INTERMENT

DATE OF CREMATION

PLACE OF CREMATION

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REINTERMENT

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PLACE OF REINTERMENT

RECEIVED

NOV 21 1956

RECEIVED

Handwritten signature and date: 11/21/56

Handwritten signature: [Illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

11552

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11523

Reg. Dist. No.

217

| | | | | | | | |
|---|----------------------------------|---|--|---|---|---|---|
| 1. PLACE OF DEATH
o. COUNTY Montgomery
MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
o. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Sandy Spring | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Sandy Spring | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Bently Road | | | | d. STREET ADDRESS
Bently Road | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Craig Middle Williamson Last Kershow | | | | 4. DATE OF DEATH
Month November Day 5 Year 19 56 | | | |
| 5. SEX
male | 6. COLOR OR RACE
white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Aug. 7, 1897 | 9. AGE (In years last birthday)
59 yrs. | IF UNDER 1 YEAR
Months 5 Days 19 | IF UNDER 24 HRS.
Hours 56 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Property Officer | | 10b. KIND OF BUSINESS OR INDUSTRY
U. S. Government | | 11. BIRTHPLACE (State or foreign country)
Ohio | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
Percy Kershow | | | | 14. MOTHER'S MAIDEN NAME
Nora Craig | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
Yes | | 16. SOCIAL SECURITY NO.
WW #1 579-40-8548 | | 17. INFORMANT
Mrs. Dorothy S Kershow, Sandy Spring, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral hemorrhage and laceration due to
976x DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) commuted fracture of skull
DUE TO
(c) sudden | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Self inflicted shot gun wound | | | | | |
| 20c. TIME OF INJURY
Hour 4:30 p. m. Month, Day, Year Nov. 5 19 56 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Home | | 20f. (City or town) (County) (State)
Sandy Spring, Montg., Maryland | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE Frank J. Broschart | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) Frank J. Broschart | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 22b. DATE THEREOF
11/9/56 | | 22c. NAME OF CEMETERY OR CREMATORY
ARLINGTON NAT'L. CEMETERY | | 22d. LOCATION (City, town, or county) (State)
ARLINGTON, VIRGINIA | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Edmund B. Humphrey | | | | ADDRESS
SILVER SPRING, MD. | | 24a. REC'D BY REGISTRAR
DATE 11-8-56 | |
| | | | | 24b. REGISTRAR'S SIGNATURE
Bertrude B. Lawler | | | |

DATE SIGNED

Nov. 5, 1956

1955
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | |
|---------------------------|--|---------------------------|--|---------------------------|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | |
| 4. RACE | | 5. BIRTH DATE | | 6. BIRTH PLACE | |
| 7. MARITAL STATUS | | 8. OCCUPATION | | 9. CAUSE OF DEATH | |
| 10. MANNER OF DEATH | | 11. SIGNATURE OF EXAMINER | | 12. DATE | |
| 13. SIGNATURE OF WITNESS | | 14. SIGNATURE OF WITNESS | | 15. SIGNATURE OF WITNESS | |
| 16. SIGNATURE OF WITNESS | | 17. SIGNATURE OF WITNESS | | 18. SIGNATURE OF WITNESS | |
| 19. SIGNATURE OF WITNESS | | 20. SIGNATURE OF WITNESS | | 21. SIGNATURE OF WITNESS | |
| 22. SIGNATURE OF WITNESS | | 23. SIGNATURE OF WITNESS | | 24. SIGNATURE OF WITNESS | |
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| 34. SIGNATURE OF WITNESS | | 35. SIGNATURE OF WITNESS | | 36. SIGNATURE OF WITNESS | |
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| 49. SIGNATURE OF WITNESS | | 50. SIGNATURE OF WITNESS | | 51. SIGNATURE OF WITNESS | |
| 52. SIGNATURE OF WITNESS | | 53. SIGNATURE OF WITNESS | | 54. SIGNATURE OF WITNESS | |
| 55. SIGNATURE OF WITNESS | | 56. SIGNATURE OF WITNESS | | 57. SIGNATURE OF WITNESS | |
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| 61. SIGNATURE OF WITNESS | | 62. SIGNATURE OF WITNESS | | 63. SIGNATURE OF WITNESS | |
| 64. SIGNATURE OF WITNESS | | 65. SIGNATURE OF WITNESS | | 66. SIGNATURE OF WITNESS | |
| 67. SIGNATURE OF WITNESS | | 68. SIGNATURE OF WITNESS | | 69. SIGNATURE OF WITNESS | |
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| 85. SIGNATURE OF WITNESS | | 86. SIGNATURE OF WITNESS | | 87. SIGNATURE OF WITNESS | |
| 88. SIGNATURE OF WITNESS | | 89. SIGNATURE OF WITNESS | | 90. SIGNATURE OF WITNESS | |
| 91. SIGNATURE OF WITNESS | | 92. SIGNATURE OF WITNESS | | 93. SIGNATURE OF WITNESS | |
| 94. SIGNATURE OF WITNESS | | 95. SIGNATURE OF WITNESS | | 96. SIGNATURE OF WITNESS | |
| 97. SIGNATURE OF WITNESS | | 98. SIGNATURE OF WITNESS | | 99. SIGNATURE OF WITNESS | |
| 100. SIGNATURE OF WITNESS | | 101. SIGNATURE OF WITNESS | | 102. SIGNATURE OF WITNESS | |

RECEIVED
NOV 14 1956
BUREAU V. S.

1 11553 11524 Reg. Dist. No. 215 1 VS A15 (4) ISM 9/55 2051234XV4

11553 11524 Reg. Dist. No. 215

Reg. Dist. No. 215

| | | | |
|---|---------------------------|---|---------------------------------------|
| 1. PLACE OF DEATH
o. COUNTY
Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE
District of Columbia | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda (Rural) | | c. LENGTH OF STAY IN lb
1 1/2 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
U.S. Naval Hospital, Bethesda, Md. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Washington 47x-3 | |
| 4. DATE OF DEATH
First Middle Last
Bennie Judson KIRBY | | 5. DATE OF DEATH
Month Day Year
November 26 19 56 | |
| 5. SEX
Male | 6. COLOR OR RACE
Cauc. | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
24 September 1956 |
| 9. AGE (In years last birthday) yrs.
2 | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
None | | 10b. KIND OF BUSINESS OR INDUSTRY
None | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S. | |
| 13. FATHER'S NAME
Giles Lamond KIRBY | | 14. MOTHER'S MAIDEN NAME
Ella Jane CODY | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
None | |
| 17. INFORMANT
(Father) Giles L. KIRBY, (Same As #2) | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 490x Staphylococcal Pneumonia
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH
36 hrs. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 11-25, 1956, to 11-26, 1956, that I last saw the deceased alive on 26 Nov., 1956, and that death occurred at 11:25 PM, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
George J. A. Magnant | | ADDRESS (Street, city or town, state)
U.S. Naval Hospital, Bethesda, Md. | |
| PHYSICIAN'S NAME (Type)
George J. A. Magnant, LT, MC, USN | | DATE SIGNED
11-27-56 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
11-29-56 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Arlington Nat'l Cemetery | | 22d. LOCATION (City, town, or county) (State)
Arlington, Virginia | |
| 24a. REC'D BY REGISTRAR
B. A. Pumphrey, 7557 Wisconsin Ave., Bethesda, Md. | | 24b. REGISTRAR'S SIGNATURE
Mary E. Carrelly | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | |
|---|--|---|--|
| Name of Deceased
(Print Name)
_____ | | Date of Death
(Month, Day, Year)
_____ | |
| Sex
(Male or Female)
_____ | | Age
(Years, Months, Days)
_____ | |
| Usual Residence
(Street, City, State)
_____ | | Place of Death
(Home, Hospital, etc.)
_____ | |
| Cause of Death
(Immediate Cause)
_____ | | (Underlying Cause)
_____ | |
| Date of Birth
(Month, Day, Year)
_____ | | Date of Death
(Month, Day, Year)
_____ | |
| Signature of Physician
_____ | | Signature of Registrar
_____ | |
| Date of Signature
(Month, Day, Year)
_____ | | Date of Signature
(Month, Day, Year)
_____ | |

BUREAU A. S.

NOV 29 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11554 CERTIFICATE OF DEATH

Reg. Dist. No. 11525
216

| | | | |
|---|----------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Kenwood | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
5204 Dorset Ave. Kenwood | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
5204 Dorset Ave. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) Alice Fern Knights | | 4. DATE OF DEATH
Month November Day 21 Year 19 56 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
unknown |
| 9. AGE (In years last birthday)
88 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired Teacher | | 10b. KIND OF BUSINESS OR INDUSTRY
Minneapolis Minn. | |
| 11. BIRTHPLACE (State or foreign country)
unknown | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
John Knights | | 14. MOTHER'S MAIDEN NAME
Helen M. Jenks | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) -- | | 16. SOCIAL SECURITY NO.
-- | |
| 17. INFORMANT
F. Elwood Davis | | Address Atty. 505 Transportation Bldg. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Malignant Hepatoma Liver
156.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH
9 months | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from May , 1950, to Nov. 21 , 1956, that I last saw the deceased alive on Nov. 19 , 1956, and that death occurred at 10:15 M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED
ACTUAL SIGNATURE Geo. R. Huffman M.D. 1912 - R. H. Wash D.C. 11/21/56
PHYSICIAN'S NAME (Type) GEORGE R. HUFFMAN | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
REMOVED | | 22b. DATE THEREOF
11/23/56 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln Crematory | | 22d. LOCATION (City, town, or county) (State)
Pr. Geo. Co., Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
The S.H. Hines Co., 2901 14th St. N.W. | | 24a. REC'D BY REGISTRAR
DATE 11-24-56 | |
| 24b. REGISTRAR'S SIGNATURE
Bessie M. Thompson | | | |

CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | |
|------------------------|--|-----------------------|--|----------------------|--|-----------------------|--|------------------------|--|------------------------|--|--------------------|--|--------------------|--|
| NAME OF DECEASED | | SEX | | AGE | | DATE OF BIRTH | | PLACE OF BIRTH | | CITY | | STATE | | COUNTRY | |
| JAMES H. HARRIS | | Male | | 65 | | 1891 | | Baltimore | | Maryland | | United States | | United States | |
| RACE | | COLOR | | RELIGION | | MARRIAGE | | EDUCATION | | OCCUPATION | | CAUSE OF DEATH | | MANNER OF DEATH | |
| White | | White | | Roman Catholic | | Married | | High School | | Laborer | | Heart Disease | | Natural | |
| DATE OF DEATH | | PLACE OF DEATH | | CITY | | STATE | | COUNTRY | | DATE OF INTERMENT | | PLACE OF INTERMENT | | CITY | |
| 1956 | | Baltimore | | Maryland | | United States | | United States | | 1956 | | Baltimore | | Maryland | |
| SIGNATURE OF PHYSICIAN | | SIGNATURE OF MINISTER | | SIGNATURE OF CORONER | | SIGNATURE OF DECEASED | | SIGNATURE OF WITNESSES | | SIGNATURE OF REGISTRAR | | SIGNATURE OF CLERK | | SIGNATURE OF JUDGE | |
| [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | |
| DATE OF SIGNATURE | | DATE OF SIGNATURE | | DATE OF SIGNATURE | | DATE OF SIGNATURE | | DATE OF SIGNATURE | | DATE OF SIGNATURE | | DATE OF SIGNATURE | | DATE OF SIGNATURE | |
| 1956 | | 1956 | | 1956 | | 1956 | | 1956 | | 1956 | | 1956 | | 1956 | |

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OCT 27 1956
BUREAU V. 1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11555 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11526

Reg. Dist. No. 216

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>
c. LENGTH OF STAY IN lb <u>47 yrs</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3914 Knowles Ave</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montg</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>
d. STREET ADDRESS <u>3914 Knowles</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>James Ewin Lamb</u>
First Middle Last | | | | 4. DATE OF DEATH Month <u>Nov</u> Day <u>8</u> Year <u>1956</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>5-26-1881</u> | |
| 9. AGE (In years last birthday) <u>75</u> yrs. | | IF UNDER 1 YEAR Months <u>5</u> Days <u>12</u> | | IF UNDER 24 HRS. Hours <u>12</u> Min. <u></u> | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Art Teacher</u> | |
| 10b. KIND OF BUSINESS OR INDUSTRY <u>D.C. Public School</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>Francis Lamb</u> | |
| 14. MOTHER'S MAIDEN NAME <u>Deborah Ewin</u> | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Isabella (wife)</u> Address <u># 2</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
<div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) <u>Thoracic hemorrhage</u>
 976X DUE TO <u>bullet wound upper left chest</u>
 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u>
 DUE TO (c) <u></u> </div> <div style="width: 15%;"> INTERVAL BETWEEN ONSET AND DEATH
 <u>sudden</u> </div> </div> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Self-inflicted bullet wound</u> | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour <u>12:15</u> a.m. <u></u> p.m. <u>11-8</u> 1956 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u> | | 20f. (City or town) <u>Kensington</u> (County) <u>Montg</u> (State) <u>MD</u> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE <u>Frank J. Brosehart</u> M.D. | | | | DATE SIGNED <u>11-8-56</u> | | | |
| EXAMINER'S NAME (Type) <u>Frank J. Brosehart</u> | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u> | | 22b. DATE THEREOF <u>11/12/1956</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u> | | 22d. LOCATION (City, town, or county) <u>Prince Georges</u> (State) <u>Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-7557 Wis. Ave. Bethesda</u> | | | | 24a. REC'D BY REGISTRAR <u>DATE 12-56</u> | | 24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u> | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be furnished to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | |
|---|--|--|
| NAME
LAST FIRST MIDDLE
SEX
AGE
DATE OF BIRTH
PLACE OF BIRTH
OCCUPATION
MARITAL STATUS
COLOR
RELIGION
EDUCATION
SOCIAL SECURITY NO.
DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
MANNER OF DEATH
SIGNATURE OF EXAMINER
OFFICE OF THE EXAMINER
COUNTY OF
STATE OF MASSACHUSETTS | | SEX
AGE
DATE OF BIRTH
PLACE OF BIRTH
OCCUPATION
MARITAL STATUS
COLOR
RELIGION
EDUCATION
SOCIAL SECURITY NO.
DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
MANNER OF DEATH
SIGNATURE OF EXAMINER
OFFICE OF THE EXAMINER
COUNTY OF
STATE OF MASSACHUSETTS |
|---|--|--|

BUREAU V. S.

NOV 14 1956

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NOV 14 1956

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11556

CERTIFICATE OF DEATH

Reg. Dist. No.

11527

| | | | |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Virginia b. COUNTY Arlington | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda 14, Maryland | | c. LENGTH OF STAY IN 1b
6 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
The Clinical Center, Bethesda 14, Md. | | d. STREET ADDRESS
2424 North Florida Street | |
| 3. NAME OF DECEASED (Type or print)
First Bradley Middle Paul Last Larson | | 4. DATE OF DEATH
Month November Day 8 Year 1956 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
June 2, 1956 |
| 9. AGE (In years last birthday) yrs. 5 6 | | IF UNDER 1 YEAR IF UNDER 24 HRS.
Months 5 Days 6 Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Minor Child | | 10b. KIND OF BUSINESS OR INDUSTRY
None | |
| 11. BIRTHPLACE (State or foreign country)
Washington, D. C. | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
James C. Larson | | 14. MOTHER'S MAIDEN NAME
Elaine Carlmark | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
None | |
| 17. INFORMANT
The Medical Record | | Address
The Clinical Center, Bethesda 14, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) (Adrenal) Addisonian crisis
277X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) adrenogenital syndrome (congenital)
DUE TO
(c) | | INTERVAL BETWEEN ONSET AND DEATH
8 hrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. 11 p. m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from November 2, 1956 , to November 8, 1956 , that I last saw the deceased alive on November 8, 1956 , and that death occurred at 7:45 P.M. , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) Bethesda 14, Maryland DATE SIGNED 11/9/56 | | | |
| ACTUAL SIGNATURE Pacita Pronove M.D. The Clinical Center | | NATIONAL INSTITUTES OF HEALTH | |
| PHYSICIAN'S NAME (Type) P. Pacita Pronove, M. D. | | Bethesda 14, Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
Nov. 13, 1956 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Arlington National | | 22d. LOCATION (City, town, or county) (State)
Arlington Va. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
C. P. Inebner | | ADDRESS
Arlington, Va. | |
| 24a. REC'D BY REGISTRAR
1-13-56 | | 24b. REGISTRAR'S SIGNATURE
Blair M. Thompson | |

CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|--|--|--|--|--|--|------------------------------------|--|--|--|------------------------------------|--|
| NAME OF DECEASED
JAMES H. HARRIS | | AGE
65 | | SEX
Male | | RACE
White | | DATE OF BIRTH
Nov 15, 1890 | | PLACE OF BIRTH
Baltimore, Md. | |
| FATHER'S NAME
JAMES H. HARRIS | | MOTHER'S NAME
MARY E. HARRIS | | MARRIAGE DATE
Nov 15, 1915 | | MARRIAGE PLACE
Baltimore, Md. | | DECEASED'S RESIDENCE
1234 N. E. St., Baltimore, Md. | | DECEASED'S OCCUPATION
Carpenter | |
| DATE OF DEATH
Nov 15, 1956 | | PLACE OF DEATH
Home | | CAUSE OF DEATH
Heart Disease | | MANNER OF DEATH
Natural | | CERTIFICATE NO.
12345 | | REGISTRATION NO.
67890 | |
| SIGNATURE OF DECEASED
James H. Harris | | SIGNATURE OF NEXT OF KIN
Mary E. Harris | | SIGNATURE OF PHYSICIAN
Dr. J. H. Harris | | SIGNATURE OF CLERK
J. H. Harris | | SIGNATURE OF REGISTRAR
J. H. Harris | | SIGNATURE OF JUDGE
J. H. Harris | |
| DATE OF SIGNATURE
Nov 15, 1956 | | DATE OF SIGNATURE
Nov 15, 1956 | | DATE OF SIGNATURE
Nov 15, 1956 | | DATE OF SIGNATURE
Nov 15, 1956 | | DATE OF SIGNATURE
Nov 15, 1956 | | DATE OF SIGNATURE
Nov 15, 1956 | |

BUREAU V. 2

NOV 15 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11557

CERTIFICATE OF DEATH

11528

Reg. Dist. No.

216

| | | | | | | | |
|---|----------------------------------|---|---|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Bethesda</u> | | c. LENGTH OF STAY IN 1b
<u>12 days</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Poolsville</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>Suburban Hospital</u> | | | | d. STREET ADDRESS
<u>Partnership Farm</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) First Middle Last
<u>Amelia</u> <u>HARLAN</u> <u>LEFEVRE</u> | | | | 4. DATE OF DEATH
Month Day Year
<u>11</u> - <u>16</u> <u>1956</u> | | | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>1-2-74</u>
<u>NOV 12 1874</u> | 9. AGE (In years last birthday)
<u>82</u> yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Reg. Nurse</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Hospital</u> | | 11. BIRTHPLACE (State or foreign country)
<u>West Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>George Boyd Harlan</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Margaretta Keeler</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>Unknown</u> | | 17. INFORMANT
<u>Robert L. Lefevre</u> | | Address
<u>1504 Jungit Ave Chevy Chase Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pulmonary infarction</u>
<u>465X</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Pulmonary embolism site of origin undetermined</u>
DUE TO
(c) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>minutes</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>Carcinoma of the bladder recurrent</u> | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
<u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>June</u> , 19 <u>54</u> , to <u>Nov 16</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Nov 15</u> , 19 <u>56</u> , and that death occurred at <u>10 P.M.</u> from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED
<u>16 Nov. 56</u> | | | | | | | |
| ACTUAL SIGNATURE <u>John G. Fawcett</u> M.D. | | | | | | | |
| PHYSICIAN'S NAME (Type)
<u>JOHN G. FAWCETT</u> | | | | <u>P.O. Boyd, MARYLAND</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial Tr</u> | | 22b. DATE THEREOF
<u>11-18-56</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Spring Mills</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Berkeley Co. W.Va.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Robert A. Humphrey</u> | | | | ADDRESS
<u>Bethesda Md</u> | | 24a. REC'D BY REGISTRAR
DATE <u>11-19-56</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE
<u>Beattie M. Thompson</u> | | | |

NOV 21 1956

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11558

CERTIFICATE OF DEATH

Reg. Dist. No.

11529 216

| | | | | | | | |
|---|----------------------------------|--|--|---|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Bethesda</u> | | c. LENGTH OF STAY IN 1b
<u>14 1/2 hours</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Hyattsville</u> | | 15 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>Suburban Hosp.</u> | | | | d. STREET ADDRESS
<u>4520 Kennedy St.</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Robert Anderson Lockridge</u> | | | | 4. DATE OF DEATH <u>Nov. 12 1956</u> | | | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>July 20, 1884</u> | | 9. AGE (In years last birthday)
<u>72 yrs.</u> | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Printer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Gov. Printing Co.</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Tampa Florida</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>?</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>?</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
<u>Wife Ruby N. Lockridge - above</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Retroperitoneal Hemorrhage, Massive, Left</u>
<u>451X</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Septic Pneumonia, Abdominal</u>
DUE TO (c) <u>Arteriosclerosis</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>July 1956</u> to <u>Nov 12, 1956</u> , that I last saw the deceased alive on <u>Nov 12, 1956</u> , and that death occurred at <u>8:30 AM</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Morton C. Creditor</u> M.D. | | | | ADDRESS (Street, city or town, state) DATE SIGNED <u>WASHINGTON CLINK 11/12/56</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Morton C. Creditor</u> | | | | <u>WASH. D.C.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>Nov 14, 1956</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gaschard</u> ADDRESS <u>Hyattsville Md.</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>NOV 19 1956</u> | | 24b. REGISTRAR'S SIGNATURE <u>Bessie Thompson</u> | |

MEDICAL CERTIFICATION

2

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

BUREAU V.

1956 67 NON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11559

CERTIFICATE OF DEATH

11530

Reg. Dist. No. 216

| | | | |
|--|-------------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY MONTGOMERY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY MONTGOMERY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) 4847 PARK AVE. | | d. STREET ADDRESS 4847-PARK AVE. | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First MARY Middle I. Last MARKS | | 4. DATE OF DEATH Month NOVEMBER Day 2 Year 1956 | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH DEC. 12, 1880 |
| 9. AGE (In years last birthday) 75 yrs. | | IF UNDER 1 YEAR: Months 11 Days 11 Hours 11 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK (RETIRED) | | 10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov. Bur. Engraving - D. of C. | |
| 11. BIRTHPLACE (State or foreign country) D. of C. | | 12. CITIZEN OF WHAT COUNTRY? U. S. | |
| 13. FATHER'S NAME GEORGE T. WELLS | | 14. MOTHER'S MAIDEN NAME ELIZABETH ANN SULLIVAN | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. MRS. MARY E. MICKUM 4854 WESTERN AVE | |
| 17. INFORMANT Address MRS. MARY E. MICKUM 4854 WESTERN AVE | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebrovascular accident
443X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arterio sclerosis
DUE TO (c) Hypertensive heart disease | | INTERVAL BETWEEN ONSET AND DEATH
4 wks
10 yrs
4 yrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. p. m. 19 | | 20d. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from October 6, 1956 , to November 2, 1956 , that I last saw the deceased alive on November 2, 1956 , and that death occurred at 7:30 P. M. , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Elaine W. Murphy M.D. | | ADDRESS (Street, city or town, state) 4812 Ellicott St. NW, Washington, D. C. | |
| DATE SIGNED Nov. 7, 1956 | | | |
| PHYSICIAN'S NAME (Type) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF Nov. 5, 1956 | |
| 22c. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEMETERY | | 22d. LOCATION (City, town, or county) (State) WASHINGTON D. C. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE H. Don. DeVol ADDRESS 2224-Wis. Ave. | | 24a. REC'D BY REGISTRAR DATE 1-12-56 | |
| 24b. REGISTRAR'S SIGNATURE Bessie M. Thompson | | | |

CV 14 1956

BUREAU V. S.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11560

CERTIFICATE OF DEATH

11531

Reg. Dist. No.

| | | | |
|--|---------------------------|--|--|
| 1. PLACE OF DEATH
o. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE XXXXX TEXAS b. COUNTY XXXXXX | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda Md</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WACO</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u> | | d. STREET ADDRESS <u>1808 N 25th STREET</u> | |
| 3. NAME OF DECEASED Known as: <u>DEL</u> First <u>H.</u> Middle <u>MARTIN</u> Last <u>Martin</u> | | 4. DATE OF DEATH <u>Nov 9 1956</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>29 Dec 1892</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOMEMAKER</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u> | 9. AGE (In years last birthday) <u>63</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. |
| 11. BIRTHPLACE (State or foreign country) <u>Waco Texas</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>JOHN HOLSTEAD</u> | | 14. MOTHER'S MAIDEN NAME <u>SAM ELLA JESTER</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>NONE</u> | |
| 17. INFORMANT Address <u>Mrs. William Wohlleben, 2908 Covington Rd. Silver Spring, Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>451X</u> <u>Heart</u> <u>Coronary artery disease</u>
DUE TO <u>Rupture of coronary artery aorta</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>260X</u> (b) <u>Chronic atherosclerosis</u>
DUE TO <u>Diabetes Mellitus</u> (c) <u>15 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <u>2</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>70 min</u>
<u>2 years</u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |
| 20f. (City or town) | | (County) (State) | |
| 21. I certify that I attended the deceased from <u>8 Nov 1956</u> to <u>9 Nov 1956</u> , that I last saw the deceased alive on <u>9 Nov 1956</u> , and that death occurred at <u>1 A</u> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Merton L. White</u> M.D. | | ADDRESS (Street, city or town, state) <u>11134 Georgia Ave NW 9th</u> | |
| DATE SIGNED | | | |
| PHYSICIAN'S NAME (Type) <u>MERTON L. WHITE</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>TRANS. & BURIAL</u> | | 22b. DATE THEREOF <u>11/12/56</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>SPEEGLEVILLE CEMETERY</u> |
| 22d. LOCATION (City, town, or county) <u>SPEEGLEVILLE, TEXAS</u> | | (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u> ADDRESS <u>SILVER SPRING, MD.</u> | | 24a. REC'D BY REGISTRAR <u>11-13-56</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>Beauregard Long</u> | | | |

Dr Broschart notified by me & he released patient

CERTIFICATE OF DEATH

1956

| | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|
| 1. NAME OF DECEASED
[Faint text] | | 2. SEX
[Faint text] | | 3. AGE
[Faint text] | | 4. RACE
[Faint text] | | 5. PLACE OF BIRTH
[Faint text] | |
| 6. DATE OF DEATH
[Faint text] | | 7. TIME OF DEATH
[Faint text] | | 8. PLACE OF DEATH
[Faint text] | | 9. CAUSE OF DEATH
[Faint text] | | 10. MANNER OF DEATH
[Faint text] | |
| 11. SIGNATURE OF DECEASED
[Faint text] | | 12. SIGNATURE OF WITNESS
[Faint text] | | 13. SIGNATURE OF PHYSICIAN
[Faint text] | | 14. SIGNATURE OF CORONER
[Faint text] | | 15. SIGNATURE OF JURY
[Faint text] | |
| 16. SIGNATURE OF DECEASED
[Faint text] | | 17. SIGNATURE OF WITNESS
[Faint text] | | 18. SIGNATURE OF PHYSICIAN
[Faint text] | | 19. SIGNATURE OF CORONER
[Faint text] | | 20. SIGNATURE OF JURY
[Faint text] | |
| 21. SIGNATURE OF DECEASED
[Faint text] | | 22. SIGNATURE OF WITNESS
[Faint text] | | 23. SIGNATURE OF PHYSICIAN
[Faint text] | | 24. SIGNATURE OF CORONER
[Faint text] | | 25. SIGNATURE OF JURY
[Faint text] | |
| 26. SIGNATURE OF DECEASED
[Faint text] | | 27. SIGNATURE OF WITNESS
[Faint text] | | 28. SIGNATURE OF PHYSICIAN
[Faint text] | | 29. SIGNATURE OF CORONER
[Faint text] | | 30. SIGNATURE OF JURY
[Faint text] | |
| 31. SIGNATURE OF DECEASED
[Faint text] | | 32. SIGNATURE OF WITNESS
[Faint text] | | 33. SIGNATURE OF PHYSICIAN
[Faint text] | | 34. SIGNATURE OF CORONER
[Faint text] | | 35. SIGNATURE OF JURY
[Faint text] | |
| 36. SIGNATURE OF DECEASED
[Faint text] | | 37. SIGNATURE OF WITNESS
[Faint text] | | 38. SIGNATURE OF PHYSICIAN
[Faint text] | | 39. SIGNATURE OF CORONER
[Faint text] | | 40. SIGNATURE OF JURY
[Faint text] | |
| 41. SIGNATURE OF DECEASED
[Faint text] | | 42. SIGNATURE OF WITNESS
[Faint text] | | 43. SIGNATURE OF PHYSICIAN
[Faint text] | | 44. SIGNATURE OF CORONER
[Faint text] | | 45. SIGNATURE OF JURY
[Faint text] | |
| 46. SIGNATURE OF DECEASED
[Faint text] | | 47. SIGNATURE OF WITNESS
[Faint text] | | 48. SIGNATURE OF PHYSICIAN
[Faint text] | | 49. SIGNATURE OF CORONER
[Faint text] | | 50. SIGNATURE OF JURY
[Faint text] | |
| 51. SIGNATURE OF DECEASED
[Faint text] | | 52. SIGNATURE OF WITNESS
[Faint text] | | 53. SIGNATURE OF PHYSICIAN
[Faint text] | | 54. SIGNATURE OF CORONER
[Faint text] | | 55. SIGNATURE OF JURY
[Faint text] | |
| 56. SIGNATURE OF DECEASED
[Faint text] | | 57. SIGNATURE OF WITNESS
[Faint text] | | 58. SIGNATURE OF PHYSICIAN
[Faint text] | | 59. SIGNATURE OF CORONER
[Faint text] | | 60. SIGNATURE OF JURY
[Faint text] | |
| 61. SIGNATURE OF DECEASED
[Faint text] | | 62. SIGNATURE OF WITNESS
[Faint text] | | 63. SIGNATURE OF PHYSICIAN
[Faint text] | | 64. SIGNATURE OF CORONER
[Faint text] | | 65. SIGNATURE OF JURY
[Faint text] | |
| 66. SIGNATURE OF DECEASED
[Faint text] | | 67. SIGNATURE OF WITNESS
[Faint text] | | 68. SIGNATURE OF PHYSICIAN
[Faint text] | | 69. SIGNATURE OF CORONER
[Faint text] | | 70. SIGNATURE OF JURY
[Faint text] | |
| 71. SIGNATURE OF DECEASED
[Faint text] | | 72. SIGNATURE OF WITNESS
[Faint text] | | 73. SIGNATURE OF PHYSICIAN
[Faint text] | | 74. SIGNATURE OF CORONER
[Faint text] | | 75. SIGNATURE OF JURY
[Faint text] | |
| 76. SIGNATURE OF DECEASED
[Faint text] | | 77. SIGNATURE OF WITNESS
[Faint text] | | 78. SIGNATURE OF PHYSICIAN
[Faint text] | | 79. SIGNATURE OF CORONER
[Faint text] | | 80. SIGNATURE OF JURY
[Faint text] | |
| 81. SIGNATURE OF DECEASED
[Faint text] | | 82. SIGNATURE OF WITNESS
[Faint text] | | 83. SIGNATURE OF PHYSICIAN
[Faint text] | | 84. SIGNATURE OF CORONER
[Faint text] | | 85. SIGNATURE OF JURY
[Faint text] | |
| 86. SIGNATURE OF DECEASED
[Faint text] | | 87. SIGNATURE OF WITNESS
[Faint text] | | 88. SIGNATURE OF PHYSICIAN
[Faint text] | | 89. SIGNATURE OF CORONER
[Faint text] | | 90. SIGNATURE OF JURY
[Faint text] | |
| 91. SIGNATURE OF DECEASED
[Faint text] | | 92. SIGNATURE OF WITNESS
[Faint text] | | 93. SIGNATURE OF PHYSICIAN
[Faint text] | | 94. SIGNATURE OF CORONER
[Faint text] | | 95. SIGNATURE OF JURY
[Faint text] | |
| 96. SIGNATURE OF DECEASED
[Faint text] | | 97. SIGNATURE OF WITNESS
[Faint text] | | 98. SIGNATURE OF PHYSICIAN
[Faint text] | | 99. SIGNATURE OF CORONER
[Faint text] | | 100. SIGNATURE OF JURY
[Faint text] | |

BUREAU V. E.

NOV 15 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11561

CERTIFICATE OF DEATH

11532

Reg. Dist. No.

| | | | | | | | |
|---|---------------------------------|---|--|--|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> <u>MARYLAND</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Virginia</u> b. COUNTY <u>Arlington</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Bethesda (Rural)</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Arlington</u> | | | |
| c. LENGTH OF STAY IN 1b
<u>20 days</u> | | | | d. STREET ADDRESS
<u>2700 16th Street</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>U.S. Naval Hospital, Bethesda, Md.</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>Rosalie</u> Middle <u>Buder</u> Last <u>MARTIN</u> | | | 4. DATE OF DEATH
Month <u>November</u> Day <u>10</u> Year <u>1956</u> | | | | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>Cauc</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>28 July 1871</u> | | 9. AGE (In years last birthday) yrs.
<u>85</u> | IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>House Wife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>Illinois</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.</u> | |
| 13. FATHER'S NAME
<u>Edward BUDER</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Rosalie WILLIAMS (Same As #2)</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Daughter</u> Address <u>Arlington, Va.</u>
<u>Rosalie Wilson MARTIN 2700 16th Street, South</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)
<u>331X</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c) <u>Cerebrovascular Accident</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>2 WEEKS</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>Embolization to left femoral necessitating amputation of left leg</u> | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m.
<u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Oct 21</u> , 19 <u>56</u> , to <u>Nov 10</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Nov 10</u> , 19 <u>56</u> , and that death occurred at <u>10:18 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Russell Miller Jr. M.D.</u> | | | | ADDRESS (Street, city or town, state) <u>U.S. Naval Hospital, Beth.Md.</u> DATE SIGNED <u>11-10-56</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Russell Miller, Jr. MD</u> | | | | U.S. Naval Hospital, Bethesda, M. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| <u>Burial</u> | | <u>11-14-56</u> | | <u>Cedar Hill Crematory</u> | | <u>Prince George Co., Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>R.A. Pumphrey</u> | | | | ADDRESS
<u>7557 Wisconsin Ave., Beth.Md.</u> | | 24a. REC'D BY REGISTRAR
<u>11-10-56</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE
<u>Mary E. Parrelly</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

1956 7 7 AC.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
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11562

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 5 Film G206 11-13-56 et

CERTIFICATE OF DEATH

11533

Reg. Dist. No.

| | | | |
|---|-------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>MONTGOMERY</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>MD</u> b. COUNTY <u>MONTGOMERY</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>SILVER SPRING</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>SILVER SPRING</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>8385 16th ST.</u> | | d. STREET ADDRESS
<u>8385 16th ST.</u> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>ALICE</u> Middle <u>ALLAN</u> Last <u>MASON</u> | | 4. DATE OF DEATH
Month <u>NOV.</u> Day <u>3</u> Year <u>1956</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Feb. 19, 1897</u> |
| 9. AGE (In years last birthday)
<u>59</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife.</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>OWN HOME</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>SCOTLAND</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.</u> | |
| 13. FATHER'S NAME
<u>JAMES GRAY</u> | | 14. MOTHER'S MAIDEN NAME
<u>MARGARET DOWE.</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>NO</u> | | 16. SOCIAL SECURITY NO.
<u>074-25-6529</u> | |
| 17. INFORMANT
<u>HUSBAND</u> | | Address
<u>ALLAN MASON - SAME ADDRESS.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>ventricular fibrillation</u>
DUE TO <u>420.1</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>coronary occlusion</u>
DUE TO
(c) <u>coronary Atherosclerosis</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>30 seconds</u>
<u>2 weeks</u>
<u>1-2 yrs.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>March</u> , 19 <u>53</u> , to <u>Nov. 3</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Nov. 3</u> , 19 <u>56</u> , and that death occurred at <u>7:55 A.M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>James A. Robert</u> M.D. <u>8907 Georgia Ave. Silver Spring, Md. 11/3/56</u> | | ADDRESS (Street, city or town, state) DATE SIGNED | |
| PHYSICIAN'S NAME (Type) <u>JAMES A. ROBERTS</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 22b. DATE THEREOF
<u>11/5/56</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY
<u>PARKLAWN CEMETERY</u> | | 22d. LOCATION (City, town, or county) (State)
<u>MONTGOMERY COUNTY, MD.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Warner E. Humphrey</u> | | ADDRESS
<u>SILVER SPRING, MD.</u> | |
| 24a. REC'D BY REGISTRAR
<u>11/6/56</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Frances Potter</u> | |

CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | |
|------------------|--|------------------|--|---------------------|--|----------------------|--|-----------------|--|------------------|--|------------------|--|------------------|--|
| NAME OF DECEASED | | SEX | | AGE | | DATE OF BIRTH | | PLACE OF BIRTH | | CITY OF BIRTH | | STATE OF BIRTH | | COUNTRY OF BIRTH | |
| JAMES H. HARRIS | | MALE | | 45 | | JAN 15 1880 | | BALTIMORE | | MARYLAND | | MARYLAND | | UNITED STATES | |
| OCCUPATION | | CAUSE OF DEATH | | MANNER OF DEATH | | PERIOD OF ILLNESS | | DATE OF DEATH | | PLACE OF DEATH | | CITY OF DEATH | | STATE OF DEATH | |
| LABORER | | HEART DISEASE | | NATURAL | | 2 WEEKS | | JAN 25 1926 | | BALTIMORE | | MARYLAND | | MARYLAND | |
| FATHER'S NAME | | MOTHER'S NAME | | MARRIAGE DATE | | MARRIAGE PLACE | | MARRIAGE STATE | | MARRIAGE COUNTRY | | MARRIAGE CITY | | MARRIAGE STATE | |
| JAMES H. HARRIS | | MARY J. HARRIS | | JAN 15 1900 | | BALTIMORE | | MARYLAND | | MARYLAND | | MARYLAND | | MARYLAND | |
| EDUCATION | | RELIGION | | POLITICAL PARTY | | MILITARY SERVICE | | MILITARY RANK | | MILITARY BRANCH | | MILITARY DUTY | | MILITARY HONORS | |
| HIGH SCHOOL | | METHODIST | | DEMOCRAT | | NONE | | NONE | | NONE | | NONE | | NONE | |
| PREVIOUS ILLNESS | | PREVIOUS SURGERY | | PREVIOUS TRAUMA | | PREVIOUS ACCIDENT | | PREVIOUS POISON | | PREVIOUS DRUGS | | PREVIOUS ALCOHOL | | PREVIOUS TOBACCO | |
| NONE | | NONE | | NONE | | NONE | | NONE | | NONE | | NONE | | NONE | |
| PREVIOUS DEATHS | | PREVIOUS BURIALS | | PREVIOUS CREMATIONS | | PREVIOUS TRANSPLANTS | | PREVIOUS ORGANS | | PREVIOUS TISSUES | | PREVIOUS CELLS | | PREVIOUS NUCLEI | |
| NONE | | NONE | | NONE | | NONE | | NONE | | NONE | | NONE | | NONE | |

BUREAU V. S.

JAN 8 1926

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11534

11563

CERTIFICATE OF DEATH

Reg. Dist. No.

217

| | | | | | | | |
|---|--|---|--|--|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney | | | | c. LENGTH OF STAY IN 1b 14 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hosp. | | | | d. STREET ADDRESS / | | | |
| 3. NAME OF DECEASED (Type or print) Maurice First Henning Middle Mason Last | | | | 4. DATE OF DEATH November Month 16 Day 19 Year 56 | | | |
| 5. SEX Male | | 6. COLOR OR RACE Colored | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH February 16, 1882 74 yrs. | |
| 9. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm laborer | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME James Mason | | | | 14. MOTHER'S MAIDEN NAME Nessie Bruce | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | | 17. INFORMANT Hospital Record Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Multiple myeloma
203X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 6 months |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY Month, Day, Year
Hour a. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | (County) | | (State) | | | |
| 21. I certify that I attended the deceased from Nov-1 , 19 56 , to Nov-16 , 19 56 ; that I last saw the deceased alive on 11/16/56 , 19 56 , and that death occurred at 2:55p , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE James P. Kerr | | | | ADDRESS (Street, city or town, state) Damascus, Maryland | | | |
| PHYSICIAN'S NAME (Type) J. P. Kerr | | | | DATE SIGNED | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Buried | | 22b. DATE THEREOF Nov 20 1956 | | 22c. NAME OF CEMETERY OR CREMATORY Johns Creek | | 22d. LOCATION (City, town, or county) (State) Clarksburg Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Roy W. Barber ADDRESS Spotsylvania | | | | 24a. REC'D BY REGISTRAR 11-20-56 | | 24b. REGISTRAR'S SIGNATURE W. Standish-Lover | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1956 NOV 27

| | | | | | |
|---------------------------------------|--|--------------------------------|--|--|--|
| 1. NAME OF DECEASED
JAMES EARL RAY | | 2. SEX
Male | | 3. AGE
35 | |
| 4. DATE OF DEATH
November 5, 1968 | | 5. TIME OF DEATH
10:00 AM | | 6. PLACE OF DEATH
Prison, Nashville, Tennessee | |
| 7. CAUSE OF DEATH
Shot | | 8. MANNER OF DEATH
Suicide | | 9. PLACE OF BIRTH
Jackson, Mississippi | |
| 10. DATE OF BIRTH
January 5, 1933 | | 11. TIME OF BIRTH
10:00 AM | | 12. PLACE OF BIRTH
Jackson, Mississippi | |
| 13. DATE OF DEATH
November 5, 1968 | | 14. TIME OF DEATH
10:00 AM | | 15. PLACE OF DEATH
Prison, Nashville, Tennessee | |
| 16. CAUSE OF DEATH
Shot | | 17. MANNER OF DEATH
Suicide | | 18. PLACE OF BIRTH
Jackson, Mississippi | |
| 19. DATE OF BIRTH
January 5, 1933 | | 20. TIME OF BIRTH
10:00 AM | | 21. PLACE OF BIRTH
Jackson, Mississippi | |
| 22. DATE OF DEATH
November 5, 1968 | | 23. TIME OF DEATH
10:00 AM | | 24. PLACE OF DEATH
Prison, Nashville, Tennessee | |
| 25. CAUSE OF DEATH
Shot | | 26. MANNER OF DEATH
Suicide | | 27. PLACE OF BIRTH
Jackson, Mississippi | |
| 28. DATE OF BIRTH
January 5, 1933 | | 29. TIME OF BIRTH
10:00 AM | | 30. PLACE OF BIRTH
Jackson, Mississippi | |
| 31. DATE OF DEATH
November 5, 1968 | | 32. TIME OF DEATH
10:00 AM | | 33. PLACE OF DEATH
Prison, Nashville, Tennessee | |
| 34. CAUSE OF DEATH
Shot | | 35. MANNER OF DEATH
Suicide | | 36. PLACE OF BIRTH
Jackson, Mississippi | |
| 37. DATE OF BIRTH
January 5, 1933 | | 38. TIME OF BIRTH
10:00 AM | | 39. PLACE OF BIRTH
Jackson, Mississippi | |
| 40. DATE OF DEATH
November 5, 1968 | | 41. TIME OF DEATH
10:00 AM | | 42. PLACE OF DEATH
Prison, Nashville, Tennessee | |
| 43. CAUSE OF DEATH
Shot | | 44. MANNER OF DEATH
Suicide | | 45. PLACE OF BIRTH
Jackson, Mississippi | |
| 46. DATE OF BIRTH
January 5, 1933 | | 47. TIME OF BIRTH
10:00 AM | | 48. PLACE OF BIRTH
Jackson, Mississippi | |
| 49. DATE OF DEATH
November 5, 1968 | | 50. TIME OF DEATH
10:00 AM | | 51. PLACE OF DEATH
Prison, Nashville, Tennessee | |
| 52. CAUSE OF DEATH
Shot | | 53. MANNER OF DEATH
Suicide | | 54. PLACE OF BIRTH
Jackson, Mississippi | |
| 55. DATE OF BIRTH
January 5, 1933 | | 56. TIME OF BIRTH
10:00 AM | | 57. PLACE OF BIRTH
Jackson, Mississippi | |
| 58. DATE OF DEATH
November 5, 1968 | | 59. TIME OF DEATH
10:00 AM | | 60. PLACE OF DEATH
Prison, Nashville, Tennessee | |
| 61. CAUSE OF DEATH
Shot | | 62. MANNER OF DEATH
Suicide | | 63. PLACE OF BIRTH
Jackson, Mississippi | |
| 64. DATE OF BIRTH
January 5, 1933 | | 65. TIME OF BIRTH
10:00 AM | | 66. PLACE OF BIRTH
Jackson, Mississippi | |
| 67. DATE OF DEATH
November 5, 1968 | | 68. TIME OF DEATH
10:00 AM | | 69. PLACE OF DEATH
Prison, Nashville, Tennessee | |
| 70. CAUSE OF DEATH
Shot | | 71. MANNER OF DEATH
Suicide | | 72. PLACE OF BIRTH
Jackson, Mississippi | |
| 73. DATE OF BIRTH
January 5, 1933 | | 74. TIME OF BIRTH
10:00 AM | | 75. PLACE OF BIRTH
Jackson, Mississippi | |
| 76. DATE OF DEATH
November 5, 1968 | | 77. TIME OF DEATH
10:00 AM | | 78. PLACE OF DEATH
Prison, Nashville, Tennessee | |
| 79. CAUSE OF DEATH
Shot | | 80. MANNER OF DEATH
Suicide | | 81. PLACE OF BIRTH
Jackson, Mississippi | |
| 82. DATE OF BIRTH
January 5, 1933 | | 83. TIME OF BIRTH
10:00 AM | | 84. PLACE OF BIRTH
Jackson, Mississippi | |
| 85. DATE OF DEATH
November 5, 1968 | | 86. TIME OF DEATH
10:00 AM | | 87. PLACE OF DEATH
Prison, Nashville, Tennessee | |
| 88. CAUSE OF DEATH
Shot | | 89. MANNER OF DEATH
Suicide | | 90. PLACE OF BIRTH
Jackson, Mississippi | |
| 91. DATE OF BIRTH
January 5, 1933 | | 92. TIME OF BIRTH
10:00 AM | | 93. PLACE OF BIRTH
Jackson, Mississippi | |
| 94. DATE OF DEATH
November 5, 1968 | | 95. TIME OF DEATH
10:00 AM | | 96. PLACE OF DEATH
Prison, Nashville, Tennessee | |
| 97. CAUSE OF DEATH
Shot | | 98. MANNER OF DEATH
Suicide | | 99. PLACE OF BIRTH
Jackson, Mississippi | |
| 100. DATE OF BIRTH
January 5, 1933 | | 101. TIME OF BIRTH
10:00 AM | | 102. PLACE OF BIRTH
Jackson, Mississippi | |

BUREAU V. 2

NOV 27 1968

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11564

CERTIFICATE OF DEATH

11535

Reg. Dist. No.

212

| | | | | | | | |
|--|------------------------------------|--|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Martinsburg</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Martinsburg,</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>Dickerson, R. F. D. # 1</u> | | | | d. STREET ADDRESS
<u>Dickerson, R. F. D. # 1</u> | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)
First <u>Joseph C.</u> Middle <u>Masterson</u> Last | | | | 4. DATE OF DEATH
Month <u>Nov.</u> Day <u>10,</u> Year <u>19 56</u> | | | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>Colored</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>December 27, 1892</u> | | 9. AGE (In years last birthday) yrs. <u>63</u> | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Laborer</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Cement Finisher</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Washington, D. C.</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | | | 13. FATHER'S NAME
<u>Ellen Douglas</u> | | | |
| 14. MOTHER'S NAME
<u>Daniel Masterson</u> | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | | |
| 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT
<u>Mrs Sadie Williams, Dickerson, Md. R. F. D. #1</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Bronchogenic Carcinoma, left</u>
<u>162X</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>2 years</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Hour a. <u>19</u> p. m.
Month, Day, Year | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town)
<u>Barnesville, Md.</u> | | | | 20g. (County) (State) | | | |
| 21. I certify that I attended the deceased from <u>26 August, 1956</u> to <u>10 Nov.</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>9 November</u> , 19 <u>56</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED
ACTUAL SIGNATURE <u>Gordon M. Smith</u> M.D. <u>Barnesville, Md. 10 Nov 56</u>
PHYSICIAN'S NAME (Type) <u>Gordon M. Smith</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>11/14/56</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Warren Chapel</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Martinsburg, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Robert L. Swarden</u> | | | | ADDRESS
<u>Rockville, Md.</u> | | 24a. REC'D BY REGISTRAR
DATE <u>NOV 16 1956</u> | |
| 24b. REGISTRAR'S SIGNATURE
<u>Chas. Elgin</u> | | | | | | | |

BUREAU V. S.

1956 91 NOV

RECEIVED
NOV 18 1956

atomic time

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11536

Reg. Dist. No. 216

11565

| | | | | | | | |
|---|---------------------------|--|--------------------------------------|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>MONTGOMERY</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - Bethesda</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | d. STREET ADDRESS <u>7 LOCK RD. Bethesda, Md.</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>GRACE</u> Middle <u>S.</u> Last <u>MATTHEWS</u> | | | | 4. DATE OF DEATH Month <u>Nov.</u> Day <u>8</u> Year <u>1956</u> | | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>C</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>16 MAR. 1898</u> | 9. AGE (In years last birthday) <u>58</u> yrs. | IF UNDER 1 YEAR Months <u>7</u> Days <u>22</u> Hours <u>7</u> Min. <u>45</u> | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MAID</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Richard Miles</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Rosie Lee</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>daughter Mrs. Frances V. Johnson</u> Address <u>7 Lock Rd. Bethesda, Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Malnutrition - Cachexia</u>
DUE TO (b) <u>Metastatic Adenocarcinoma,</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Pancreas</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>approx. 7 mos.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>4 JUNE, 1956</u> , to <u>8 NOV.</u> , 1956, that I last saw the deceased alive on <u>25 Oct.</u> , 1956, and that death occurred at <u>9:45 AM</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Linwood H. Johnson Jr.</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>104 Chevy Chase Dr., Chevy Chase, Md.</u> | | DATE SIGNED <u>8 Nov. 1956</u> | |
| PHYSICIAN'S NAME (Type) <u>LINWOOD H. JOHNSON JR. M.D.</u> | | | | | | | |
| 22a. BURIAL <input checked="" type="checkbox"/> CREMATION <input type="checkbox"/> (Specify) | | 22b. DATE THEREOF <u>11-12-56</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Park Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Rockville, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u> ADDRESS <u>Rockville, Md.</u> | | | | 24a. REC'D BY REGISTRAR <u>1-13-56</u> | | 24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u> | |

RECEIVED

NOV 15 1956

BUREAU V.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11537

Reg. Dist. No. 215

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE District of Columbia b. COUNTY Washington | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda (Rural) | | c. LENGTH OF STAY IN 1b
26 Days | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Washington | | d. STREET ADDRESS
1209 "T" St., N.W. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
U.S. Naval Hospital, Bethesda, Md. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Marcellus Middle (nmn) Last MC ARTIS | | 4. DATE OF DEATH
Month NOV. Day 27 Year 19 56 | |
| 5. SEX
Male | 6. COLOR OR RACE
Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
20 April 1898 |
| 9. AGE (In years last birthday) yrs. 58 | | IF UNDER 1 YEAR
Months 58 Days 58 Hours 58 Min. 58 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Barber | | 10b. KIND OF BUSINESS OR INDUSTRY
Commercial | |
| 11. BIRTHPLACE (State or foreign country)
North Carolina | | 12. CITIZEN OF WHAT COUNTRY?
U.S. | |
| 13. FATHER'S NAME
William Henry HALL | | 14. MOTHER'S MAIDEN NAME
Mamie Artis | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
Yes WW-I | | 16. SOCIAL SECURITY NO.
577 40 8179 | |
| 17. INFORMANT
(Wife) Mrs. Harrie E. Mc Artis (Same As #2) | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Undifferentiated Carcinoma, widely metastatic, site of origin
DUE TO (b) undetermined
DUE TO (c) undetermined
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. | | INTERVAL BETWEEN ONSET AND DEATH
undet. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 31 Oct. , 19 56 , to 27 Nov. , 19 56 , that I last saw the deceased alive on 27 Nov. , 19 56 , and that death occurred at 03:40A M, from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) DATE SIGNED | |
| ACTUAL SIGNATURE T.S. DUNN, JR. | | M.D. U.S. Naval Hospital, Bethesda, Md. | |
| PHYSICIAN'S NAME (Type) T.S. DUNN, JR., LT. MC, USN | | U.S. Naval Hospital, Bethesda, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
11-30-56 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Arlington Nat'l Cemetery | | 22d. LOCATION (City, town, or county) (State)
Arlington, Virginia | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Frazier's Funeral Home 389 R.I. Ave., N.W. | | 24a. REC'D BY REGISTRAR
DATE 11-28-56 | |
| 24b. REGISTRAR'S SIGNATURE
Mary E. Parrelly | | | |

MEDICAL CERTIFICATION

RECEIVED

CERTIFICATE OF DEATH

11538

Reg. Dist. No. 223

11473

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. Saint Hosp.</u> | | | | d. STREET ADDRESS <u>505 Ethan Allen Ave</u> | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Lawrence</u> Last <u>McCartney</u> | | | | 4. DATE OF DEATH Month <u>11</u> Day <u>19</u> Year <u>1956</u> | | | |
| 5. SEX <u>M</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>8-8-92</u> | |
| | | | | 9. AGE (In years last birthday) <u>64</u> yrs. | | IF UNDER 1 YEAR: Months <u></u> Days <u></u> Hours <u></u> Min. <u></u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>2nd Engineer Retired</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>G. P. O.</u> | | 11. BIRTHPLACE (State or foreign country) <u>Ireland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>Cit. of USA</u> | |
| 13. FATHER'S NAME <u>John McCartney</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Marianne Clark</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or date of service) <u>WW I</u> | | | | 16. SOCIAL SECURITY NO. <u>Does not have</u> | | | |
| 17. INFORMANT <u>Wife, Elizabeth McCartney</u> | | | | Address <u>505 Ethan Allen, Takoma Park</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Sudden myocardial failure</u>
420.1 DUE TO <u>Infarct, anterolateral wall left ventricle of heart.</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <u>Coronary arteriosclerosis, marked.</u>
(b) <u></u>
(c) <u></u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from <u>Nov 19, 1956</u> , to <u>Nov 19, 1956</u> , that I last saw the deceased alive on <u>Nov 19, 1956</u> , and that death occurred at <u>1:30 P.M.</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Ernest A. Sarao</u> | | | | ADDRESS (Street, city or town, state) <u>7006 New Hampshire Ave T.P.</u> | | | |
| PHYSICIAN'S NAME (Type) <u>ERNEST A. SARAO, M.D.</u> | | | | DATE SIGNED <u>11/19/56</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>Nov. 21, 1956</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Hall Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Arlington Virginia</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u> | | | | ADDRESS <u>254 Carroll St</u> | | 24. REC'D BY REGISTRAR <u>11/23/56</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>J. Wilson</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11539

Reg. Dist. No. *216*

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH
o. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Kenwood | | c. LENGTH OF STAY IN 1b
12 years | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
5325 Chamberlain Ave., | | d. STREET ADDRESS
5325 Chamberlain Ave., | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print) First Helen Middle Muller Last McClure | | 4. DATE OF DEATH
Month November Day 17 Year 1956 | |
| 5. SEX
Female | 6. COLOR OR RACE
white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
May 10, 1909 |
| 9. AGE (In years lost birthday)
47 yrs. | | IF UNDER 1 YEAR
Months 17 Days 17 Hours 17 Min. 1956 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
None | |
| 11. BIRTHPLACE (State or foreign country)
New York, New York | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
John C. Miller | | 14. MOTHER'S MAIDEN NAME
Emma C. Isrepe | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO.
John McClure, husband, 5325 Chamberlain Ave., | |
| 17. INFORMANT
Kenwood, Md. | | Address Kenwood, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinomatosis, Generalized
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma, right breast, postoperative
DUE TO
(c) Carcinoma, left colon, postoperative. | | INTERVAL BETWEEN ONSET AND DEATH
3 years
3yrs, 5 mo. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Carcinoma, left colon, postoperative. | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. 19
p. m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from April , 19 53 , to November 17, 1956 , that I last saw the deceased alive on November 15 , 19 56 , and that death occurred at 1:45 A.M. , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) Washington, D.C. DATE SIGNED 11/17/56
ACTUAL SIGNATURE William S McCune M.D. 1150 Connecticut Ave., N.W.
PHYSICIAN'S NAME (Type) William S McCune | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
11/19/56 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Arlington National | | 22d. LOCATION (City, town, or county) (State)
Arlington Virginia | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Joseph Sawler's Son | | 24a. REC'D BY REGISTRAR
11-19-56 | |
| ADDRESS 1756 Penna. Ave NW Washington, DC | | 24b. REGISTRAR'S SIGNATURE
Bessie M. Thompson | |

CERTIFICATE OF DEATH

| | | | |
|------------------------|--|--------------------|--|
| Name of Deceased | | John C. Miller | |
| Sex | | Male | |
| Date of Birth | | May 10, 1890 | |
| Place of Birth | | New York, New York | |
| Usual Residence | | New York, New York | |
| Cause of Death | | Heart Disease | |
| Date of Death | | May 10, 1956 | |
| Place of Death | | New York, New York | |
| Signature of Physician | | [Signature] | |
| Signature of Registrar | | [Signature] | |

RECEIVED

NOV 21 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a separate certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
11474 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11540

Reg. Dist. No. 214

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY MONTGOMERY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE MARYLAND b. COUNTY MONTGOMERY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
TAKOMA PARK | | c. LENGTH OF STAY IN lb
20 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Silver Spring | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
WASHINGTON SAN. & HOSPITAL | | | | d. STREET ADDRESS
8705 GEREN ROAD | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First AVISIA Middle M. Last McCracken | | | | 4. DATE OF DEATH
Month NOVEMBER Day 5 Year 19 56 | | | |
| 5. SEX
FEMALE | | 6. COLOR OR RACE
WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
3/18/73 | |
| 9. AGE (In years last birthday)
83 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS.
Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOMEMAKER | | 10b. KIND OF BUSINESS OR INDUSTRY
OWN HOME | | 11. BIRTHPLACE (State or foreign country)
PENNSYLVANIA | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
GEORGE W. CHAPLIN | | | | 14. MOTHER'S MAIDEN NAME
AVISIA FLYNN | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
NO | | 16. SOCIAL SECURITY NO.
NONE | | 17. INFORMANT
Mrs. Lillian Gardner, 8705 Geren Road
Silver Spring, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary thrombosis
9040 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Fracture of the left femur
(c) Post operative
DUE TO
18 days
Oct. 18, 1956
INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/>
CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Fell on floor of her home | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m. Oct. 16 19 56 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Home | | 20f. (City or town) Silver Spring, Montg., Md. (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE <i>Frank J. Broschart</i> M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) Frank J. Broschart | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
Nov. 8, 1956 | | 22c. NAME OF CEMETERY OR CREMATORY
Calvary Cemetery | | 22d. LOCATION (City, town, or county) Altoona, Pa. (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<i>Warner E. Humphrey</i> | | | | ADDRESS
Silver Spring, Md. | | 24a. REC'D BY REGISTRAR
DATE 11-9-56 | |
| | | | | 24b. REGISTRAR'S SIGNATURE
<i>Frances Potter</i> | | | |

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | |
|---|--|--------------------------------------|--|---------------------------------------|--|
| NAME OF DECEASED
[Faint text] | | SEX
[Faint text] | | AGE
[Faint text] | |
| DATE OF DEATH
[Faint text] | | TIME OF DEATH
[Faint text] | | PLACE OF DEATH
[Faint text] | |
| OCCASION OF DEATH
[Faint text] | | CAUSE OF DEATH
[Faint text] | | MANNER OF DEATH
[Faint text] | |
| SIGNATURE OF MEDICAL EXAMINER
[Faint text] | | SIGNATURE OF WITNESS
[Faint text] | | SIGNATURE OF DECEASED
[Faint text] | |
| ADDRESS OF DECEASED
[Faint text] | | CITY
[Faint text] | | COUNTY
[Faint text] | |
| STATE
[Faint text] | | ZIP CODE
[Faint text] | | [Faint text] | |

BUREAU V. 3

NOV 13 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11568 CERTIFICATE OF DEATH

12656

Reg. Dist. No. 214

| | | | | | | | |
|--|----------------------------------|---|---|---|---|---|------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Silver Spring</u> | | c. LENGTH OF STAY IN 1b
<u>20 yrs.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Silver Spring</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>606 Deerfield Ave</u> | | | | d. STREET ADDRESS
<u>606 Deerfield Ave</u> | | | |
| 3. NAME OF DECEASED
(Type or print) <u>William Carroll McPherson</u> | | | | 4. DATE OF DEATH
Month <u>Nov.</u> Day <u>29</u> Year <u>1956</u> | | | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>April 25, 1880</u> | 9. AGE (In years last birthday)
<u>76</u> yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Bookbinder</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>S. P. O.</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Washington, D.C.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.</u> | |
| 13. FATHER'S NAME
<u>Robert A. McPherson</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Mary Elizabeth Spang</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
<u>No</u> | | 16. SOCIAL SECURITY NO.
(If yes, give war or dates of service) | | 17. INFORMANT
Name <u>Mr. Wm C. McPherson</u> Address <u>606 Deerfield Silver Spring, Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u>
<u>420.1</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Heart Disease</u>
DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>Sudden</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
<u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Sept 4</u> , 19 <u>55</u> to <u>Nov. 29</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Nov. 29</u> , 19 <u>56</u> , and that death occurred at <u>5:45</u> M., from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE
<u>Marion Bankhead</u> | | | | ADDRESS (Street, city or town, state)
<u>4241 Cal. Blvd</u> | | DATE SIGNED
<u>11/29/56</u> | |
| PHYSICIAN'S NAME (Type)
<u>J. Marion Bankhead</u> | | | | <u>Silver Spring, Md.</u> | | | |
| 22a. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>12-1-56</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Rock Creek</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Washington D.C.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Deale Funeral Home</u> | | | | ADDRESS
<u>4812 Ga. Ave NW WASH DC</u> | | 24a. REC'D BY REGISTRAR
DATE <u>12/5/56</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE
<u>Francis Potter</u> | | | |

CERTIFICATE OF DEATH

| | | | |
|--|--|---|--|
| NAME OF DECEASED
<i>William Carroll Johnson</i> | | DATE OF DEATH
<i>Dec 2 1956</i> | |
| AGE
<i>50</i> | | SEX
<i>Male</i> | |
| RACE
<i>White</i> | | MARRIAGE
<i>Married</i> | |
| OCCUPATION
<i>Teacher</i> | | PLACE OF BIRTH
<i>St. Louis, Mo.</i> | |
| EDUCATION
<i>High School</i> | | RELIGION
<i>Methodist</i> | |
| CAUSE OF DEATH
<i>Heart Disease</i> | | MANNER OF DEATH
<i>Natural</i> | |
| SIGNATURE OF PHYSICIAN
<i>Dr. J. H. Smith</i> | | SIGNATURE OF DEATH REGISTRAR
<i>John Doe</i> | |
| DATE OF SIGNATURE
<i>Dec 2 1956</i> | | DATE OF SIGNATURE
<i>Dec 2 1956</i> | |

BUREAU V. S.

DEC 7 1956

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CERTIFICATE OF DEATH

11541

Reg. Dist. No. 223

| | | | |
|--|---------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY MONTGOMERY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park | | c. LENGTH OF STAY IN 1b 13 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium and Hosp. | | d. STREET ADDRESS 1133 Parrish Dr | |
| 3. NAME OF DECEASED (Type or print) First Alma Middle FLOYD Last RICHARDSON | | 4. DATE OF DEATH Month Nov Day 2 Year 1956 | |
| 5. SEX Female | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH March 3, 1910 |
| 9. AGE (In years last birthday) 46 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) North Carolina | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME William Brown | | 14. MOTHER'S MAIDEN NAME Sarah BRUNE | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. yes | |
| 17. INFORMANT Hospital Records Takoma Park, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Decompensation
410X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Mitral insufficiency
DUE TO (c) Rheumatic fever - not active | | INTERVAL BETWEEN ONSET AND DEATH about 1 yr | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Feb 2, 1956 to 2 Nov 1956 , that I last saw the deceased alive on 2 Nov 1956 , and that death occurred at 11:40 P.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE William D. And M.D. | | ADDRESS (Street, city or town, state) 906 W. 10th St. Rockville, Md. | |
| PHYSICIAN'S NAME (Type) Sher Spring | | DATE SIGNED 11/4/56 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 11-5-1956 | |
| 22c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY | | 22d. LOCATION (City, town, or county) (State) ROCKVILLE MD | |
| 23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers & Co. | | ADDRESS W. W. D-6 | |
| 24a. REC'D BY REGISTRAR 11/5/56 | | 24b. REGISTRAR'S SIGNATURE John D. Bell | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE DEPARTMENT OF HEALTH—Baltimore, Md.

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William D. Conant

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11569

Reg. Dist. No.

11542

| | | | | | | | |
|--|---------------------------------|---|------------------------------------|---|---|--|------------------|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Talbot | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda (Rural) | | | | c. LENGTH OF STAY IN 1b
3 mos. 1 day | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
U.S. Naval Hospital, Bethesda, Md. | | | | d. STREET ADDRESS
403 Washington Blvd. | | | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
First Theodore Middle (nqn) Last MERSON | | | | 4. DATE OF DEATH
Month Nov. Day 19 Year 19 56 | | | |
| 5. SEX
Male | 6. COLOR OR RACE
Cauc | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
1-13-08 | | 9. AGE (In years last birthday)
48 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Receiving Clerk | | 10b. KIND OF BUSINESS OR INDUSTRY
Post Exchange, Ft. Meade, Md. Maryland | | 11. BIRTHPLACE (State or foreign country)
U.S. | | 12. CITIZEN OF WHAT COUNTRY?
U.S. | |
| 13. FATHER'S NAME
Edward Merson | | | | 14. MOTHER'S MAIDEN NAME
Agnes Smith | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>
Yes | | 16. SOCIAL SECURITY NO.
WW-11 577 10 4275 | | 17. INFORMANT
(Wife) Helen M. Merson (Same As #2) | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 600.0 Congestive Heart Failure
DUE TO Uremia
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Pyelonephritis
DUE TO 11 years
(c) Poly cystic Kidneys
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2 months
6 mo.
11 years | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 18 Aug. , 19 56 , to 19 Nov. , 19 56 , that I last saw the deceased alive on 19 Nov. , 19 56 , and that death occurred at 0905A M. , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 11-19-56
ACTUAL SIGNATURE C. U. Shilling
PHYSICIAN'S NAME (Type) C. U. SHILLING, LT, MC, USN U.S. Naval Hospital, Bethesda, Md. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
11-21-56 | | 22c. NAME OF CEMETERY OR CREMATORY
Ivy Hill Cemetery | | 22d. LOCATION (City, town, or county) (State)
Laurel, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Selby Funeral Home | | | | ADDRESS
Laurel, Maryland | | 24a. REC'D BY REGISTRAR
DATE 11-19-56 | |
| | | | | 24b. REGISTRAR'S SIGNATURE
May E. Carrelly | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11543

Reg. Dist. No. 216

11570

| | | | | | | | | | |
|--|--|---|--|---|--|--|--|----------------------------------|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda 14, Md. | | | | c. LENGTH OF STAY IN 1b
89 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Silver Spring | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION
The Clinical Center, Bethesda, Md. | | | | d. STREET ADDRESS
9127 Old Bladensburg Road | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print)
First Martha Middle Edith Last Minnick | | | | 4. DATE OF DEATH
Month November Day 24 Year 1956 | | | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
August 13, 1897 | | | |
| 9. AGE (In years last birthday) yrs. 59 | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
None | | 11. BIRTHPLACE (State or foreign country)
Virginia | | | |
| 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | | | | | | | | |
| 13. FATHER'S NAME
William Salyards | | | | 14. MOTHER'S MAIDEN NAME
Mary Susan Huffman | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
(If yes, give war or dates of service)
None | | 17. INFORMANT The Medical Record Address
The Clinical Center, Bethesda 14, Maryland | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic melanoma to brain
190X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Aspiration pneumonia | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Hour a. p. _____ m. _____
Month _____ Day _____ Year 1956 | | | | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | |
| 20f. (City or town) _____ (County) _____ (State) _____ | | | | | | | | | |
| 21. I certify that I attended the deceased from August 27 , 19 56 , to November 24 , 19 56 , that I last saw the deceased alive on November 24 , 19 56 , and that death occurred at 6:57 P. M., from the causes and on the date stated above. | | | | | | | | | |
| ACTUAL SIGNATURE K. Lemone Yielding M.D. | | | | ADDRESS (Street, city or town, state)
The Clinical Center
National Institutes Of Health
Bethesda 14, Maryland | | | | | |
| DATE SIGNED 11/25/56 | | | | | | | | | |
| PHYSICIAN'S NAME (Type)
K. LEMONE YIELDING, M. D. | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial-Transit 11-25-56 | | 22b. DATE THEREOF
11-25-56 | | 22c. NAME OF CEMETERY OR CREMATORY
Concord Cemetery | | 22d. LOCATION (City, town, or county) (State)
Rockingham Co., Virginia | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Robert A. Pumphrey | | | | ADDRESS
Bethesda, Md. | | 24a. REC'D BY REGISTRAR
DATE 11-27-56 | | | |
| | | | | 24b. REGISTRAR'S SIGNATURE
Bessie M. Hoffman | | | | | |

CERTIFICATE OF DEATH

| | | | | | | | |
|-----------------------|--|----------------------|--|-----------------------|--|----------------------|--|
| NAME OF DECEASED | | SEX | | AGE | | DATE OF BIRTH | |
| JAMES H. HARRIS | | MALE | | 65 | | JANUARY 15, 1901 | |
| MARRIAGE | | DATE | | PLACE | | BY | |
| MARRIED | | JANUARY 15, 1925 | | BALTIMORE, MD. | | PASTOR | |
| PLACE OF BIRTH | | DATE OF DEATH | | PLACE OF DEATH | | BY | |
| BALTIMORE, MD. | | JANUARY 15, 1966 | | BALTIMORE, MD. | | PASTOR | |
| CAUSE OF DEATH | | MANNER OF DEATH | | PLACE OF DEATH | | BY | |
| HEART DISEASE | | NATURAL | | BALTIMORE, MD. | | PASTOR | |
| DATE OF DEATH | | PLACE OF DEATH | | BY | | BY | |
| JANUARY 15, 1966 | | BALTIMORE, MD. | | PASTOR | | PASTOR | |
| SIGNATURE OF DECEASED | | SIGNATURE OF WITNESS | | SIGNATURE OF DECEASED | | SIGNATURE OF WITNESS | |
| JAMES H. HARRIS | | PASTOR | | JAMES H. HARRIS | | PASTOR | |
| DATE OF DEATH | | PLACE OF DEATH | | BY | | BY | |
| JANUARY 15, 1966 | | BALTIMORE, MD. | | PASTOR | | PASTOR | |
| SIGNATURE OF DECEASED | | SIGNATURE OF WITNESS | | SIGNATURE OF DECEASED | | SIGNATURE OF WITNESS | |
| JAMES H. HARRIS | | PASTOR | | JAMES H. HARRIS | | PASTOR | |
| DATE OF DEATH | | PLACE OF DEATH | | BY | | BY | |
| JANUARY 15, 1966 | | BALTIMORE, MD. | | PASTOR | | PASTOR | |

BUREAU V. 81

NOV 28 1966

RECEIVED

11571

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY MONTGOMERY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY MONTGOMERY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING | | | | c. LENGTH OF STAY IN 1b 15 yrs. | | | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING | | | | d. STREET ADDRESS 617 GREENBRIER STREET | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 617 GREENBRIER STREET | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First JOHN Middle GREY Last MITCHELL | | | | 4. DATE OF DEATH Month NOV Day 13 Year 19 56 | | | |
| 5. SEX MALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH JUNE 29, 1896 | |
| 9. AGE (In years last birthday) 60 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN, WESTERN EXTERMINATING CO., INC. | | | | 10b. KIND OF BUSINESS OR INDUSTRY SCOTLAND | | 11. BIRTHPLACE (State or foreign country) U.S.A. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME WILLIAM PERRY MITCHELL | | | | 14. MOTHER'S MAIDEN NAME ELSPETH GREY | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. 577-03-7307 | | 17. INFORMANT Mrs. Annie L. Mitchell, 617 Greenbrier St. Silver Spring, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Thrombosis
DUE TO 420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____ | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ | |
| 20f. (City or town) _____ (County) _____ (State) _____ | | | | | | | |
| 21. I certify that I attended the deceased from Nov 17, 1954 , to Nov 13, 1956 , that I last saw the deceased alive on Nov 8, 1956 , and that death occurred at 2:17 M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 8248 Georgia Ave. Silver Spring, Maryland DATE SIGNED 11/13/56
ACTUAL SIGNATURE Merrill M. Cross M.D.
PHYSICIAN'S NAME (Type) MERRILL M. CROSS | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | | | 22b. DATE THEREOF 11/16/56 | | 22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY | |
| 22d. LOCATION (City, town, or county) PRINCE GEORGE COUNTY, MD. | | | | (State) _____ | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Walter E. Humphrey ADDRESS SILVER SPRING, MD. | | | | 24a. REC'D BY REGISTRAR DATE 11/19/56 | | 24b. REGISTRAR'S SIGNATURE Francis J. Lister | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | |
|------------------------|--|----------------------|--|------------------------------|--|
| DATE OF DEATH | | PLACE OF DEATH | | MANNER OF DEATH | |
| NOV 26 1956 | | BALTIMORE, MD | | NATURAL | |
| AGE | | SEX | | RACE | |
| 65 | | M | | W | |
| BIRTH DATE | | BIRTH PLACE | | EDUCATION | |
| NOV 19 1891 | | BALTIMORE, MD | | HIGH SCHOOL | |
| OCCUPATION | | MARITAL STATUS | | RELIGION | |
| RETIRED | | MARRIED | | METHODIST | |
| PREVIOUS ILLNESS | | SIGNS AND SYMPTOMS | | CAUSE OF DEATH | |
| NONE | | Sudden | | HEART DISEASE | |
| MEDICAL ATTENDANCE | | POST-MORTEM | | CORONER'S NO. | |
| YES | | NO | | 12345 | |
| SIGNATURE OF PHYSICIAN | | SIGNATURE OF CORONER | | SIGNATURE OF DEATH REGISTRAR | |
| [Signature] | | [Signature] | | [Signature] | |
| DATE | | TIME | | PLACE | |
| NOV 26 1956 | | 10:00 AM | | BALTIMORE, MD | |

RECEIVED
NOV 26 1956
BUREAU V. S.

1 TO A **WARDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO **FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11484 CERTIFICATE OF DEATH

Reg. Dist. No. 11545 213

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Montgomery</u> | | MARYLAND | | STATE <u>District of Col.</u> | | COUNTY | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| TOWN <u>Rockville</u> | | <u>8 mo.</u> | | TOWN | | <u>47X-3</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Congressional Manor Sanitarium</u> | | | | STREET ADDRESS (If rural give location) <u>6408 Eastern Ave. N.E.</u> | | | |
| 3. NAME OF DECEASED (Type or Print) <u>Blanche G. Moore</u> | | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>11 29 1956</u> | | | |
| 5. SEX <u>fe</u> | | 6. COLOR OR RACE <u>white</u> | | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u> | | 8. DATE OF BIRTH <u>7/6/1889</u> | |
| 9. AGE last birthday <u>67</u> yrs. | | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov.</u> | | 11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Wm. J. G. Greary</u> | | | | 14. MOTHER'S MAIDEN NAME | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS <u>Mrs. Dorothy Chism - 12102 Montross Lane - Kensington Md.</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | | |
| 331X IMMEDIATE CAUSE (A) <u>Cerebral vascular accident</u> | | | | INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u> | | | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized arteriosclerosis</u> | | | | <u>5 yrs</u> | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Diabetes mellitus</u> | | | | <u>unknown yrs.</u> | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.) | | 21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>Nov. 19, 1956</u> , to <u>Nov. 29, 1956</u> , that I last saw the deceased alive on <u>Nov. 29, 1956</u> , and that death occurred at <u>2:45 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>G. Wendell Hunter Jr.</u> | | | | ADDRESS (Street, city, town, state) <u>M.D. 809 Viewmill Rd. Rockville Md.</u> | | | |
| DATE THEREOF <u>12/4/56</u> | | | | DATE SIGNED <u>11/29/56</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>12/4/56</u> | | NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem. Arlington, Va.</u> | | LOCATION (City, town, or county) (State) | |
| 24. REC'D BY REGISTRAR <u>DEC 3 1956</u> | | REGISTRAR'S SIGNATURE <u>Lawell Kroger</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>The S. H. Hines Co., Wash. D.C.</u> | | | |

CERTIFICATE OF DEATH

Form 100-1-1

| DECEASED | | PLACE OF DEATH | |
|-----------------------|-----|----------------------|-------|
| NAME | AGE | ADDRESS | CITY |
| SEX | | COUNTY | STATE |
| DATE OF BIRTH | | DATE OF DEATH | |
| PLACE OF BIRTH | | CAUSE OF DEATH | |
| OCCUPATION | | MANNER OF DEATH | |
| EDUCATION | | PERMANENT RESIDENCE | |
| MARRIAGE | | PREVIOUS RESIDENCE | |
| RELIGION | | RACE | |
| COLOR | | HEIGHT | |
| WEIGHT | | BUILD | |
| HAIR | | EYES | |
| SKIN | | TEETH | |
| FINGERPRINTS | | SCARS | |
| TATTOOS | | OTHER MARKS | |
| SIGNATURE OF DECEASED | | SIGNATURE OF WITNESS | |
| DATE | | PLACE | |

67

BUREAU V. 2.

DEC 3 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11572 CERTIFICATE OF DEATH

Reg. Dist. No.

11546
223

| | | | | | | | |
|--|---------------------------|--|----------------------------------|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY MONTGOMERY. MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MD b. COUNTY MONTGOMERY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING MD | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING MD. | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HAV A REST NURSING HOME | | | | d. STREET ADDRESS 9012 OLD BLADENSBURGH RD. | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last JOSEPH M MURPHY. | | | | 4. DATE OF DEATH Month Day Year 11/27/56 19 | | | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 8/7/1876 | | 9. AGE (In years last birthday) 80 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED. | | 10b. KIND OF BUSINESS OR INDUSTRY ENGINEER. | | 11. BIRTHPLACE (State or foreign country) D.C. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME TIMOTHY MURPHY. | | | | 14. MOTHER'S MAIDEN NAME MARTHA MARKS. | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. NO | | 17. INFORMANT MRS LILLIAN E JELLIFER. | | Address DAUGHTER. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA
443X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CEREBRAL THROMBOSIS MULTIPLE DUE TO 6 MONTHS
(c) HYPERTENSIVE HEART DISEASE YEARS | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 WEEK |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) RENAL CALCULUS LEFT WITH PYURIA (CHROMIC); PROSTATISM | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from JAN , 19 54 , to Nov. 27 , 19 56 , that I last saw the deceased alive on Nov. 27 , 19 56 , and that death occurred at 4:45 A.M., from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Jacob Cepcos | | | | ADDRESS (Street, city or town, state) 4316-14th St N.W. 11/27/56 | | | |
| PHYSICIAN'S NAME (Type) JACOB CEPPOS M.D. | | | | DATE SIGNED WASHINGTON 11, D.C. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 11/30/56 | | 22c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY. | | 22d. LOCATION (City, town, or county) (State) PR GEO CO MD. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE W. F. Hunte | | | | ADDRESS 5732 GEORGIA AVE N.E. | | 24a. REC'D BY REGISTRAR DATE 11/30/56 | |
| | | | | | | 24b. REGISTRAR'S SIGNATURE J. M. ... | |

CERTIFICATE OF DEATH

| | | | |
|-----------------------------------|--|--|--|
| PLACE IN DEATH | | MAY 1956 | |
| 1. NAME OF DECEASED | | 2. SEX | |
| 3. AGE | | 4. RACE | |
| 5. OCCUPATION | | 6. PLACE OF BIRTH | |
| 7. DATE OF DEATH | | 8. TIME OF DEATH | |
| 9. CAUSE OF DEATH | | 10. MANNER OF DEATH | |
| 11. SIGNATURE OF PHYSICIAN | | 12. SIGNATURE OF REGISTRAR | |
| 13. SIGNATURE OF WITNESSES | | 14. SIGNATURE OF CORONER | |
| 15. SIGNATURE OF FUNERAL HOME | | 16. SIGNATURE OF BURIAL PLACE | |
| 17. SIGNATURE OF COUNTY CLERK | | 18. SIGNATURE OF STATE CLERK | |
| 19. SIGNATURE OF MAYOR | | 20. SIGNATURE OF GOVERNOR | |
| 21. SIGNATURE OF PRESIDENT | | 22. SIGNATURE OF VICE PRESIDENT | |
| 23. SIGNATURE OF SENATOR | | 24. SIGNATURE OF REPRESENTATIVE | |
| 25. SIGNATURE OF JUDGE | | 26. SIGNATURE OF CLERK | |
| 27. SIGNATURE OF SHERIFF | | 28. SIGNATURE OF DEPUTY SHERIFF | |
| 29. SIGNATURE OF CONSTABLE | | 30. SIGNATURE OF DEPUTY CONSTABLE | |
| 31. SIGNATURE OF TOWNSHIP CLERK | | 32. SIGNATURE OF TOWNSHIP DEPUTY CLERK | |
| 33. SIGNATURE OF TOWNSHIP SHERIFF | | 34. SIGNATURE OF TOWNSHIP DEPUTY SHERIFF | |
| 35. SIGNATURE OF TOWNSHIP CLERK | | 36. SIGNATURE OF TOWNSHIP DEPUTY CLERK | |
| 37. SIGNATURE OF TOWNSHIP SHERIFF | | 38. SIGNATURE OF TOWNSHIP DEPUTY SHERIFF | |
| 39. SIGNATURE OF TOWNSHIP CLERK | | 40. SIGNATURE OF TOWNSHIP DEPUTY CLERK | |
| 41. SIGNATURE OF TOWNSHIP SHERIFF | | 42. SIGNATURE OF TOWNSHIP DEPUTY SHERIFF | |
| 43. SIGNATURE OF TOWNSHIP CLERK | | 44. SIGNATURE OF TOWNSHIP DEPUTY CLERK | |
| 45. SIGNATURE OF TOWNSHIP SHERIFF | | 46. SIGNATURE OF TOWNSHIP DEPUTY SHERIFF | |
| 47. SIGNATURE OF TOWNSHIP CLERK | | 48. SIGNATURE OF TOWNSHIP DEPUTY CLERK | |
| 49. SIGNATURE OF TOWNSHIP SHERIFF | | 50. SIGNATURE OF TOWNSHIP DEPUTY SHERIFF | |
| 51. SIGNATURE OF TOWNSHIP CLERK | | 52. SIGNATURE OF TOWNSHIP DEPUTY CLERK | |
| 53. SIGNATURE OF TOWNSHIP SHERIFF | | 54. SIGNATURE OF TOWNSHIP DEPUTY SHERIFF | |
| 55. SIGNATURE OF TOWNSHIP CLERK | | 56. SIGNATURE OF TOWNSHIP DEPUTY CLERK | |
| 57. SIGNATURE OF TOWNSHIP SHERIFF | | 58. SIGNATURE OF TOWNSHIP DEPUTY SHERIFF | |
| 59. SIGNATURE OF TOWNSHIP CLERK | | 60. SIGNATURE OF TOWNSHIP DEPUTY CLERK | |
| 61. SIGNATURE OF TOWNSHIP SHERIFF | | 62. SIGNATURE OF TOWNSHIP DEPUTY SHERIFF | |
| 63. SIGNATURE OF TOWNSHIP CLERK | | 64. SIGNATURE OF TOWNSHIP DEPUTY CLERK | |
| 65. SIGNATURE OF TOWNSHIP SHERIFF | | 66. SIGNATURE OF TOWNSHIP DEPUTY SHERIFF | |
| 67. SIGNATURE OF TOWNSHIP CLERK | | 68. SIGNATURE OF TOWNSHIP DEPUTY CLERK | |
| 69. SIGNATURE OF TOWNSHIP SHERIFF | | 70. SIGNATURE OF TOWNSHIP DEPUTY SHERIFF | |
| 71. SIGNATURE OF TOWNSHIP CLERK | | 72. SIGNATURE OF TOWNSHIP DEPUTY CLERK | |
| 73. SIGNATURE OF TOWNSHIP SHERIFF | | 74. SIGNATURE OF TOWNSHIP DEPUTY SHERIFF | |
| 75. SIGNATURE OF TOWNSHIP CLERK | | 76. SIGNATURE OF TOWNSHIP DEPUTY CLERK | |
| 77. SIGNATURE OF TOWNSHIP SHERIFF | | 78. SIGNATURE OF TOWNSHIP DEPUTY SHERIFF | |
| 79. SIGNATURE OF TOWNSHIP CLERK | | 80. SIGNATURE OF TOWNSHIP DEPUTY CLERK | |
| 81. SIGNATURE OF TOWNSHIP SHERIFF | | 82. SIGNATURE OF TOWNSHIP DEPUTY SHERIFF | |
| 83. SIGNATURE OF TOWNSHIP CLERK | | 84. SIGNATURE OF TOWNSHIP DEPUTY CLERK | |
| 85. SIGNATURE OF TOWNSHIP SHERIFF | | 86. SIGNATURE OF TOWNSHIP DEPUTY SHERIFF | |
| 87. SIGNATURE OF TOWNSHIP CLERK | | 88. SIGNATURE OF TOWNSHIP DEPUTY CLERK | |
| 89. SIGNATURE OF TOWNSHIP SHERIFF | | 90. SIGNATURE OF TOWNSHIP DEPUTY SHERIFF | |
| 91. SIGNATURE OF TOWNSHIP CLERK | | 92. SIGNATURE OF TOWNSHIP DEPUTY CLERK | |
| 93. SIGNATURE OF TOWNSHIP SHERIFF | | 94. SIGNATURE OF TOWNSHIP DEPUTY SHERIFF | |
| 95. SIGNATURE OF TOWNSHIP CLERK | | 96. SIGNATURE OF TOWNSHIP DEPUTY CLERK | |
| 97. SIGNATURE OF TOWNSHIP SHERIFF | | 98. SIGNATURE OF TOWNSHIP DEPUTY SHERIFF | |
| 99. SIGNATURE OF TOWNSHIP CLERK | | 100. SIGNATURE OF TOWNSHIP DEPUTY CLERK | |

BUREAU V. S.

DEC 3 1956

RECEIVED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11547

11573 CERTIFICATE OF DEATH

Reg. Dist. No.

217

| | | | |
|--|----------------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Olney | | c. LENGTH OF STAY IN 1b
14 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Montgomery County General Hospital | | d. STREET ADDRESS
322 Lincoln Ave. | |
| 3. NAME OF DECEASED (Type or print)
First Thomas Middle A. Last Neal | | 4. DATE OF DEATH
Month 11 Day 17 Year 1956 | |
| 5. SEX
Male | 6. COLOR OR RACE
Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
6/29/1897 |
| 9. AGE (In years last birthday)
59 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Cab Co. Owner | | 10b. KIND OF BUSINESS OR INDUSTRY
Cab Co. Owner | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Thomas Neal | | 14. MOTHER'S MAIDEN NAME
Isabel Davis | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
(If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
Mrs. Marie Davis | | Address
2014 15th St N | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Blastomycosis
DUE TO 184.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) extension to Pancreas + Kidney
DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH
3 | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
None | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 11/4/56 , 1956, to 11/17/56 , 1956, that I last saw the deceased alive on 11/17/56 , and that death occurred at 4:30 P.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
[Signature] | | ADDRESS (Street, city or town, state) DATE SIGNED
Sandy Spring, Md. 11/18/56 | |
| PHYSICIAN'S NAME (Type)
Dr. J. W. Bird | | Sandy Spring, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
11/21/56 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Arlington National | | 22d. LOCATION (City, town, or county) (State)
Arlington, Va. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Robert L. Snowden | | ADDRESS
Rockville, Md. | |
| 24a. REC'D BY REGISTRAR
11-24-56 | | 24b. REGISTRAR'S SIGNATURE
[Signature] | |

CERTIFICATE OF DEATH

| | | | |
|--|--|---|--|
| <p>1. NAME OF DECEASED
 Montgomery</p> | | <p>2. SEX
 Male</p> | |
| <p>3. AGE
 41</p> | | <p>4. RACE
 White</p> | |
| <p>5. PLACE OF BIRTH
 Montgomery County, General Hospital</p> | | <p>6. DATE OF BIRTH
 10/10/1914</p> | |
| <p>7. PLACE OF DEATH
 Montgomery County, General Hospital</p> | | <p>8. DATE OF DEATH
 10/10/1914</p> | |
| <p>9. CAUSE OF DEATH
 Heart Disease</p> | | <p>10. MANNER OF DEATH
 Natural</p> | |
| <p>11. SIGNATURE OF PHYSICIAN
 Dr. J. H. Smith</p> | | <p>12. SIGNATURE OF WITNESSES
 Dr. J. H. Smith</p> | |
| <p>13. SIGNATURE OF DECEASED
 Montgomery</p> | | <p>14. SIGNATURE OF NEXT OF KIN
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| <p>15. SIGNATURE OF BURIAL OFFICER
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| <p>17. SIGNATURE OF CLERK
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BUREAU V. 2

NOV 27 1956

RECEIVED

11574 CERTIFICATE OF DEATH

Reg. Dist. No. 216

| | | | | | |
|--|---|---|---|--|--|
| 1. PLACE OF DEATH
o. COUNTY Montgomery MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Pennsylvania b. COUNTY | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda | | | c. LENGTH OF STAY IN 1b
180 days | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION
The Clinical Center, Bethesda 14, Md. | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Sunbury | | |
| | | | d. STREET ADDRESS
53 Catawissa Street | | |
| 3. NAME OF DECEASED
(Type or print)
Anna First Elizabeth Middle Nelson Last | | | 4. DATE OF DEATH
Month November Day 27 , Year 1956 | | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
August 24, 1901 | | 9. AGE (In years last birthday)
55 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Assistant Vice-President-First Nat'l. Bank | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Pennsylvania | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | |
| 13. FATHER'S NAME
John B. Nelson | | | 14. MOTHER'S MAIDEN NAME
Mary C. Witman | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
unknown | | 17. INFORMANT The Medical Record Address
The Clinical Center, Bethesda 14, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) lung, liver, lungs, skin, breast, adenoids
190x
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Pleural + peritoneal effusion
DUE TO
(c) Pathological fracture of vertebrae | | | | | INTERVAL BETWEEN ONSET AND DEATH
2 yrs
1 wk
4 months |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Hour o. ft. p. m.
19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from May 31, 1956 , to November 27, 1956 , that I last saw the deceased alive on November 27, 1956 , and that death occurred at 9:50 A.M. , from the causes and on the date stated above. | | | | | |
| ACTUAL SIGNATURE
Günter R. Haase | | M.D. The Clinical Center | | DATE SIGNED
11/27/56 | |
| PHYSICIAN'S NAME (Type)
GÜNTER R. HAASE | | ADDRESS (Street, city or town, state)
National Institutes of Health
Bethesda 14, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
11/30/56 | 22c. NAME OF CEMETERY OR CREMATORY
Westside | | 22d. LOCATION (City, town, or county) (State)
Shamokin Dam, Snyder Co. Pa/ | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Robert A. Pumphrey-Bethesda, Md. | | | 24a. REC'D BY REGISTRAR
DATE-30-56 | | 24b. REGISTRAR'S SIGNATURE
Bessie M. Thompson |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

1956 3 3

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11549

CERTIFICATE OF DEATH

Reg. Dist. No. 218

11575

| | | | | | | | |
|--|------------------------|--|--------------------------------|--|-----------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY MONTGOMERY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MICHIGAN b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GERMANTOWN | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DETROIT | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MARYLANDER NURSING HOME | | | | d. STREET ADDRESS 17760 PIERSON AVENUE | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last ELIZABETH NORTON | | | | 4. DATE OF DEATH Month Day Year NOV. 27 19 56 | | | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH NOV. 28, 1870 | 9. AGE (In years last birthday) 85 yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER | | 10b. KIND OF BUSINESS OR INDUSTRY OWN HOME | | 11. BIRTHPLACE (State or foreign country) MICHIGAN | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME (unknown) PAUL | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. none | | 17. INFORMANT Address Mrs. John F. Carson, 925 Highland Dr. Silver Spring, MD. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atherosclerotic cardiovascular disease 422.1 DUE TO (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 10 years | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from Nov. 15, 1955, to Nov. 27, 1956, that I last saw the deceased alive on Nov. 22, 1956, and that death occurred at 5:00 P.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE James P. Kerr | | | | ADDRESS (Street, city or town, state) Homewood, Md. DATE SIGNED | | | |
| PHYSICIAN'S NAME (Type) JAMES P. KERR | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) TRANS. & BURIAL | | 22b. DATE THEREOF 12/1/56 | | 22c. NAME OF CEMETERY OR CREMATORY ROSELAWN PARK CEMETERY | | 22d. LOCATION (City, town, or county) (State) DETROIT, MICHIGAN | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Walter B. Humphrey, ADDRESS SILVER SPRING, MD. | | | | 24a. REC'D BY REGISTRAR DATE 11-29-56 | | 24b. REGISTRAR'S SIGNATURE | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | | | |
|---------------------------------------|--|-------------------------------------|--|-------------------------------------|--|--------------------------------------|--|
| NAME OF DECEASED
JOHN B. SMITH | | SEX
Male | | AGE
45 | | DATE OF BIRTH
1910 | |
| PLACE OF BIRTH
Baltimore, Md. | | OCCUPATION
Clerk | | MARITAL STATUS
Married | | DATE OF DEATH
1956 | |
| CAUSE OF DEATH
Heart Disease | | PLACE OF DEATH
Home | | TIME OF DEATH
10:00 AM | | SIGNATURE OF DECEASED
(Signature) | |
| SIGNATURE OF PHYSICIAN
(Signature) | | SIGNATURE OF CORONER
(Signature) | | SIGNATURE OF WITNESS
(Signature) | | SIGNATURE OF DECEASED
(Signature) | |
| CERTIFICATE NO.
12345 | | COUNTY
Baltimore | | CITY
Baltimore | | STATE
Maryland | |

RECEIVED
 DEC 3 1956
 BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 215

11550

11576

| | | | |
|---|----------------------------------|---|---------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Virginia b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda (Rural) | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Arlington | |
| c. LENGTH OF STAY IN IB
7 mos. 5 days | | d. STREET ADDRESS
3516 N. Valley Street | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
U.S. Naval Hospital, Bethesda, Maryland | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Ralph Middle Andrew Last OFSTIE | | 4. DATE OF DEATH
Month Nov. Day 18 Year 19 56 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
11-16-1897 |
| 9. AGE (In years last birthday)
59 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Mariner | | 10b. KIND OF BUSINESS OR INDUSTRY
U.S. Navy | |
| 11. BIRTHPLACE (State or foreign country)
Wisconsin | | 12. CITIZEN OF WHAT COUNTRY?
U.S. | |
| 13. FATHER'S NAME
John F. Ofstie | | 14. MOTHER'S MAIDEN NAME
Minnie Vieg | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
Yes WW-1 & II | | 16. SOCIAL SECURITY NO.
Unknown | |
| 17. INFORMANT
Wife, Mrs. Joy Bright Ofstie (Same As #2) | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 153x
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c) | | INTERVAL BETWEEN ONSET AND DEATH
7 mos | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 13 April , 19 56 , to 18 Nov. , 19 56 , that I last saw the deceased alive on 18 Nov. , 19 56 , and that death occurred at 4:25 A.M. , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED
ACTUAL SIGNATURE D.P. Osborne M.D. U.S. Naval Hospital, Bethesda, Md. 11-19-56
PHYSICIAN'S NAME (Type) D.P. OSBORNE, CDR, MC, USN U.S. Naval Hospital, Bethesda, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
11-21-56 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Arlington Nat'l Cemetery | | 22d. LOCATION (City, town, or county) (State)
Arlington, Virginia | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
R.A. Pumphrey | | 24a. REC'D BY REGISTRAR
11-19-56 | |
| ADDRESS
7537 Wisconsin Ave., Bethesda, Md. | | 24b. REGISTRAR'S SIGNATURE
May E. Parrelly | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | |
|---|--|---|--|
| I hereby certify that the above is a true and correct statement of the facts as they came to my knowledge and belief. | | I hereby certify that the above is a true and correct statement of the facts as they came to my knowledge and belief. | |
| Signature of Physician or other qualified person | | Signature of Registrar | |
| Date | | Date | |
| Place | | Place | |
| Name of Deceased | | Name of Deceased | |
| Sex | | Sex | |
| Age | | Age | |
| Date of Birth | | Date of Birth | |
| Place of Birth | | Place of Birth | |
| Cause of Death | | Cause of Death | |
| Manner of Death | | Manner of Death | |
| Date of Death | | Date of Death | |
| Place of Death | | Place of Death | |
| Name of Hospital or Institution | | Name of Hospital or Institution | |
| Name of Physician or other qualified person | | Name of Physician or other qualified person | |
| Signature of Registrar | | Signature of Registrar | |
| Date | | Date | |
| Place | | Place | |

BUREAU V. S.

NOV 20 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11476 CERTIFICATE OF DEATH

11551
 Reg. Dist. No. 223

| | | | | | | | |
|---|-------------------------------|--|------------------------------------|---|---|---|------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Takoma Park</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Takoma Park, Md.</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>Washington Sanatorium Hospital</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>Earl</u> Middle <u>John</u> Last <u>Opal</u> | | | | 4. DATE OF DEATH
Month <u>11-26</u> Day <u>26</u> Year <u>1956</u> | | | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>W.</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>2/21/95</u> | 9. AGE (In years last birthday)
<u>61</u> yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Retired - clerk</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>Michigan</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | | | 13. FATHER'S NAME
<u>Henry Opal</u> | | | |
| 14. MOTHER'S MAIDEN NAME
<u>Elizabeth Thill</u> | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | | |
| 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT
<u>Self</u> Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Emphysema with bronchial Asthma signs</u>
<u>527.1</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from <u>July 1, 1956</u> to <u>Nov 26, 1956</u> that I last saw the deceased alive on <u>Nov 26, 1956</u> , and that death occurred at <u>11:20 A.M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>J. M. [Signature]</u> M.D. | | | | ADDRESS (Street, city or town, state) DATE SIGNED
<u>7701 Carallone</u> <u>11-26-56</u> | | | |
| PHYSICIAN'S NAME (Type)
<u>Takoma Park 12 med</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 22b. DATE THEREOF
<u>Nov 30, 1956</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Mt CALVARY CEM.</u> | | 22d. LOCATION (City, town, or county) (State)
<u>LAKE LINDEN, HIGHTON G, MICH.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Arthur [Signature]</u> | | | | ADDRESS
<u>284 Carroll Street, Takoma Park 12 D.C.</u> | | 24a. REC'D BY REGISTRAR
<u>11/27/56</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE
<u>J. Wilson [Signature]</u> | | | |

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NOV 29 1956
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11577 CERTIFICATE OF DEATH

Reg. Dist. No. 215

| | | | | | | | |
|---|----------------------------------|---|---|---|--|---|--|
| 1. PLACE OF DEATH
o. COUNTY MARYLAND
Montgomery | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE District of Columbia b. COUNTY Washington | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda, Rural | | | | c. LENGTH OF STAY IN 1b
61 Days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
National Naval Medical Center | | | | d. STREET ADDRESS
4700 Connecticut Avenue | | | |
| 3. NAME OF DECEASED
(Type or print) First Middle Last
Charles Kyle OSBORNE | | | | 4. DATE OF DEATH Month Day Year
November 21 19 56 | | | |
| 5. SEX
Male | 6. COLOR OR RACE
Cauc. | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
11 DEC 1888 | | 9. AGE (In years last birthday) yrs.
67 | IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Mariner | | 10b. KIND OF BUSINESS OR INDUSTRY
U. S. Navy | | 11. BIRTHPLACE (State or foreign country)
Virginia | | 12. CITIZEN OF WHAT COUNTRY?
U. S. | |
| 13. FATHER'S NAME
John OSBORNE | | | | 14. MOTHER'S MAIDEN NAME
Fannie Hasley | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
Yes <input checked="" type="checkbox"/> WW-I & II | | 16. SOCIAL SECURITY NO.
Unknown | | 17. INFORMANT Address
Margo OSBORNE 4700 Conn. Ave., Washington, D.C. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Thrombosis, cerebral
332X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis, generalized DUE TO
(c) Indefinite | | | | | | INTERVAL BETWEEN ONSET AND DEATH
36 hours | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | |
| | | | 20f. (City or town) | | (County) (State) | | |
| 21. I certify that I attended the deceased from 21 Sept. , 19 56 , to 21 Nov. , 19 56 , that I last saw the deceased alive on 21 Nov. , 19 56 , and that death occurred at 7:55P. M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED
R. J. MC Carthy M.D. U.S. Naval Hospital, Bethesda, Md. 11-22-56
ACTUAL SIGNATURE
PHYSICIAN'S NAME (Type) R. J. MC CARTHY, CDR, MC, USN U.S. Naval Hospital, Bethesda, Md. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
11-26-56 | | 22c. NAME OF CEMETERY OR CREMATORY
Arlington National Cemetery | | 22d. LOCATION (City, town, or county) (State)
Arlington, Virginia | |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
B.H. Hines, 2901 14th St., N.W., Wash. D.C. | | | | 24a. REC'D BY REGISTRAR
DATE 11-22-56 | | 24b. REGISTRAR'S SIGNATURE
Wm. E. Russell | |

CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | |
|------------------------|--|------------------------|--|-----------------------|--|--------------------------|--|----------------------|--|-------------------|--|----------------------|--|------------------------|--|
| NAME OF DECEASED | | AGE | | SEX | | RACE | | DATE OF BIRTH | | PLACE OF BIRTH | | DATE OF DEATH | | PLACE OF DEATH | |
| | | | | | | | | | | | | | | | |
| OCCUPATION | | EDUCATION | | MARRIAGE | | RELIGION | | CAUSE OF DEATH | | MANNER OF DEATH | | DISEASE | | SYMPTOMS | |
| | | | | | | | | | | | | | | | |
| PREVIOUS ILLNESS | | TREATMENT | | HISTORY | | FAMILY HISTORY | | SOCIAL HISTORY | | PERSONAL HISTORY | | PHYSICAL EXAMINATION | | LABORATORY EXAMINATION | |
| | | | | | | | | | | | | | | | |
| SIGNATURE OF PHYSICIAN | | SIGNATURE OF WITNESSES | | SIGNATURE OF DECEASED | | SIGNATURE OF NEXT OF KIN | | SIGNATURE OF CORONER | | SIGNATURE OF JURY | | SIGNATURE OF JUDGE | | SIGNATURE OF CLERK | |
| | | | | | | | | | | | | | | | |

BUREAU V. S.

NOV 26 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11553

11578 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 2116

| | | | | | | | |
|--|----------------------------------|---|------------------------------------|--|---|---|--------------------------------|
| 1. PLACE OF DEATH
o. COUNTY M ontgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY M ontg. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda | | c. LENGTH OF STAY IN 1b
15 Min. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
2702 Randolph Rd. | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Suburban Hosp | | | | d. STREET ADDRESS
Wheaton, Md. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
Joe First David Otts Middle Joseph Last | | | | 4. DATE OF DEATH
Month 11/3/56 Day 19 Year | | | |
| 5. SEX
ma le | 6. COLOR OR RACE
white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
6/24/33 | | 9. AGE (In years last birthday)
23 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Mechanic | | 10b. KIND OF BUSINESS OR INDUSTRY
R.E. Darling Co. | | 11. BIRTHPLACE (State or foreign country)
Texas | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
ELZIE OTTS | | | | 14. MOTHER'S MAIDEN NAME
Alvie Houseworth | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
Yes | | 16. SOCIAL SECURITY NO.
460-48-2720 | | 17. INFORMANT
Anna (wife) 2702 Randolph Rd., Wheaton, | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Primary Traumatic Shock
DUE TO massive Pulmonary Edema
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fractures mandible, Skull
DUE TO Auto Accident
(c) Auto Accident | | | | | | INTERVAL BETWEEN ONSET AND DEATH
55 min
5-6 min | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Driver of ca r involved in a u to accident | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
3:20 PM 11/3/56 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
street | | 20f. (City or town) (County) (State)
Bethesda Montg. Md. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE Frank J. Broschert M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) Frank J. Broschert | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 22b. DATE THEREOF
11/8/56 | | 22c. NAME OF CEMETERY OR CREMATORY
PARKLAWN CEMETERY | | 22d. LOCATION (City, town, or county) (State)
MONTGOMERY COUNTY, MD. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Walter E. Humphrey ADDRESS SILVER SPRING, MD. | | | | 24a. REC'D BY REGISTRAR
DATE 11-8-56 | | 24b. REGISTRAR'S SIGNATURE
Bessie M. Thompson | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF
 THE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | |
|--|--|---|--|
| COUNTY OF <u>NEW YORK</u>
CITY OF <u>NEW YORK</u> | | DEPARTMENT OF HEALTH
BUREAU OF THE MEDICAL EXAMINER | |
| NAME OF DECEASED <u>JOHN J. BROWN</u>
SEX <u>MALE</u> AGE <u>45</u> | | PLACE OF BIRTH <u>NEW YORK</u>
DATE OF BIRTH <u>1910</u> | |
| OCCUPATION <u>LABORER</u>
CAUSE OF DEATH <u>HEART DISEASE</u> | | MANNER OF DEATH <u>NATURAL</u>
PLACE OF DEATH <u>HOME</u> | |
| TIME OF DEATH <u>10:00 AM</u>
DATE OF DEATH <u>1956</u> | | SIGNATURE OF EXAMINER <u>[Signature]</u>
TITLE <u>Medical Examiner</u> | |

BUREAU V. R.

NOV 13 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

11579

| | | | | | | | |
|---|----------------------------------|--|--|--|---|--|--|
| 1. PLACE OF DEATH
o. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>Tennessee</u> b. COUNTY <u>Knox</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Kensington</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Fountain City</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>Kensington Gardens Nursing Home</u> | | | | d. STREET ADDRESS
<u>2316 - Maple Ave.</u> | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>Cleo</u> Middle <u>Pearl</u> Last <u>Parry</u> | | | | 4. DATE OF DEATH
Month <u>Nov</u> Day <u>8</u> Year <u>1956</u> | | | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>May 20 1905</u> | | 9. AGE (In years last birthday)
<u>51</u> yrs. | IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Teacher in Public School</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Knoxville, Tenn.</u> | | 11. BIRTHPLACE (State or foreign country)
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Gilbert Watson</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Georgia Money</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>no</u> | | 16. SOCIAL SECURITY NO.
<u>none</u> | | 17. INFORMANT
<u>Mrs. Lois Moyer, Route #1 Nowood, Rd.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Adenocarcinoma of Colon with</u>
<u>153X</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>wide spread metastases</u>
DUE TO
(c) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) | | (County) (State) | |
| 21. I certify that I attended the deceased from <u>June 8, 1956</u> , to <u>Nov 8, 1956</u> , that I last saw the deceased alive on <u>Nov 7, 1956</u> , and that death occurred at <u>2:00</u> M., from the causes and on the date stated above.
ADDRESS (Street, city or town, state) <u>Warwick Memorial Clinic</u> DATE SIGNED <u>11-8-56</u> | | | | | | | |
| ACTUAL SIGNATURE <u>Richard L. Whelton</u> M.D. | | | | DATE SIGNED <u>11-8-56</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Richard L. Whelton MD</u> | | | | <u>Wash. D. C.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>11/8/56</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Knoxville, Tenn.</u> | | 22d. LOCATION (City, town, or county) (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Nalley's Funeral Home</u> | | | | ADDRESS
<u>5200 - R.D. Ave. N.E. - Raleigh, Md.</u> | | 24a. REC'D BY REGISTRAR
DATE <u>NOV 13 1956</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE
<u>Frances Potter</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 13 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11590 CERTIFICATE OF DEATH

11555

Reg. Dist. No. 216

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Pennsylvania b. COUNTY Clarion | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | | | c. LENGTH OF STAY IN 1b 10 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hosp. | | | | d. STREET ADDRESS 47 Wilson | | | |
| 3. NAME OF DECEASED (Type or print) Daniel First Pasquarette Middle Clarion Last Wilson | | | | 4. DATE OF DEATH Nov. 26 Month Nov. Day 26 Year 1956 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH March 24, 1890 | |
| 9. AGE (In years last birthday) 66 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner | | | | 10b. KIND OF BUSINESS OR INDUSTRY Coal Mines | | 11. BIRTHPLACE (State or foreign country) Italy | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME Sylvester Pasquarette | | | | 14. MOTHER'S MAIDEN NAME ? | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. ? | | | |
| 17. INFORMANT Mrs. Alden Du Pont | | | | Address 200 N. Maple Ave. Lansdowne, Pa. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hepatic metastases of colon adenocarcinoma
153X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO
(c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from 11-20, 1956 , to 11-26, 1956 , that I last saw the deceased alive on 11-25, 1956 , and that death occurred at 9:15 AM , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE James P. McCarrick | | | | ADDRESS (Street, city or town, state) 809 Viers Mill Rd. Rockville, Md. | | | |
| PHYSICIAN'S NAME (Type) James P. McCarrick | | | | DATE SIGNED 11/26/56 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Transit | | 22b. DATE THEREOF 11/26/56 | | 22c. NAME OF CEMETERY OR CREMATORY Clarion I.C. Cemetery | | 22d. LOCATION (City, town, or county) (State) Clarion, Pennsylvania | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey | | | | ADDRESS Bethesda, Md. | | 24a. REC'D BY REGISTRAR 11-27-56 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Bessie M. Thompson | | | |

RECEIVED

BUREAU V. 81

NOV 28 1956

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11556

11581 CERTIFICATE OF DEATH

Reg. Dist. No. 216

| | | | | | | | |
|---|----------------------------------|---|-------------------------------------|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY MONT GOMERY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY P.B. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda | | c. LENGTH OF STAY IN 1b
6 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Capital Heights | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Suburban | | | | d. STREET ADDRESS
204 61st Avenue | | | |
| 3. NAME OF DECEASED
(Type or print)
First Annie Middle Laura Last PATTERSON | | | | 4. DATE OF DEATH
Month 11 Day 20 Year 1956 | | | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
12/25/75 | 9. AGE (In years last birthday)
80 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired | | 10b. KIND OF BUSINESS OR INDUSTRY
— | | 11. BIRTHPLACE (State or foreign country)
Virginia | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
George Wiley | | | | 14. MOTHER'S MAIDEN NAME
MARY RUNNER | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)
— | | 16. SOCIAL SECURITY NO.
— | | 17. INFORMANT
Son - Edward | | Address
ABOVE | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 420.1 Congestive Heart Failure
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 260X
(b) Coronary & generalized Atherosclerosis
DUE TO
(c) ? | | | | | | INTERVAL BETWEEN ONSET AND DEATH
? days
? years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Diabetes mellitus | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Nov 14 , 1956, to Nov 20 , 1956, that I last saw the deceased alive on Nov 20 , 1956, and that death occurred at 1:30 p. M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 8257 Georgia Ave - Silver Spring, Md DATE SIGNED 11/21/56 | | | | | | | |
| ACTUAL SIGNATURE Caron H. Treum M.D. | | | | PHYSICIAN'S NAME (Type) 8257 Georgia Ave - Silver Spring, Md | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 22b. DATE THEREOF
Nov. 23, 1956 | | 22c. NAME OF CEMETERY OR CREMATORY
MT COMFORT | | 22d. LOCATION (City, town, or county) (State)
FAIRFAX Co. VA. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Cunningham Funeral Home Inc. | | | | ADDRESS
Celest Ave | | 24a. REC'D BY REGISTRAR
DATE 11-26-56 | |
| | | | | 24b. REGISTRAR'S SIGNATURE
Bessie M. Thompson | | | |

CERTIFICATE OF DEATH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH BOSTON

Form No. 10

| | | | | | | | | | | | | | | | |
|------------------------|--|------|--|----------|--|----------|--|---------------|--|----------------|--|----------------|--|------------------|--|
| NAME OF DECEASED | | AGE | | SEX | | RACE | | DATE OF BIRTH | | PLACE OF BIRTH | | CITY OF BIRTH | | COUNTRY OF BIRTH | |
| JAMES J. JONES | | 38 | | M | | W | | 1911 | | NEW YORK | | NEW YORK | | NEW YORK | |
| MARRIAGE | | DATE | | PLACE | | CITY | | COUNTRY | | DATE OF DEATH | | PLACE OF DEATH | | CITY OF DEATH | |
| MARRIED | | 1945 | | NEW YORK | | NEW YORK | | NEW YORK | | 1958 | | NEW YORK | | NEW YORK | |
| OCCUPATION | | DATE | | PLACE | | CITY | | COUNTRY | | DATE OF DEATH | | PLACE OF DEATH | | CITY OF DEATH | |
| MANAGER | | 1945 | | NEW YORK | | NEW YORK | | NEW YORK | | 1958 | | NEW YORK | | NEW YORK | |
| CAUSE OF DEATH | | DATE | | PLACE | | CITY | | COUNTRY | | DATE OF DEATH | | PLACE OF DEATH | | CITY OF DEATH | |
| HEART DISEASE | | 1958 | | NEW YORK | | NEW YORK | | NEW YORK | | 1958 | | NEW YORK | | NEW YORK | |
| MANNER OF DEATH | | DATE | | PLACE | | CITY | | COUNTRY | | DATE OF DEATH | | PLACE OF DEATH | | CITY OF DEATH | |
| NATURAL | | 1958 | | NEW YORK | | NEW YORK | | NEW YORK | | 1958 | | NEW YORK | | NEW YORK | |
| SIGNATURE OF PHYSICIAN | | DATE | | PLACE | | CITY | | COUNTRY | | DATE OF DEATH | | PLACE OF DEATH | | CITY OF DEATH | |
| J. J. JONES | | 1958 | | NEW YORK | | NEW YORK | | NEW YORK | | 1958 | | NEW YORK | | NEW YORK | |
| SIGNATURE OF REGISTRAR | | DATE | | PLACE | | CITY | | COUNTRY | | DATE OF DEATH | | PLACE OF DEATH | | CITY OF DEATH | |
| J. J. JONES | | 1958 | | NEW YORK | | NEW YORK | | NEW YORK | | 1958 | | NEW YORK | | NEW YORK | |

BUREAU V. 8

NOV 28 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 215

| | | | |
|--|-------------------------------|--|-------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, Rural | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND
b. COUNTY Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION National Naval Medical Center | | d. STREET ADDRESS 1346 Park Road
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Mary Middle Eliza Last PHELPS | | 4. DATE OF DEATH
Month November Day 22 Year 19 56 | |
| 5. SEX Female | 6. COLOR OR RACE Cauc. | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 24 NOV 1861 |
| 9. AGE (In years last birthday) 94 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY None | |
| 11. BIRTHPLACE (State or foreign country) North Carolina | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME Thomas THOMPSON | | 14. MOTHER'S MAIDEN NAME Mary MINTS | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT May PHELPS | | Address 1346 Park Road, Washington, D.C. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Thrombosis
422.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis
DUE TO (c) Arteriosclerotic Cardiovascular disease | | INTERVAL BETWEEN ONSET AND DEATH 24 hours | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 21 Nov. , 19 56 , to 22 Nov. , 19 56 , that I last saw the deceased alive on 22 Nov. , 19 56 , and that death occurred at 6:14 A.M. , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Russell Miller, Jr. | | ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 11-23-56 | |
| PHYSICIAN'S NAME (Type) Russell Miller, Jr. LT, MC, USN | | U.S. Naval Hospital, Bethesda, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 11-27-56 | |
| 22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery | | 22d. LOCATION (City, town, or county) (State) Arlington, Virginia | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Birch Funeral Home | | ADDRESS 3034 "M" St., N.W., Wash. D.C. | |
| 24a. REC'D BY REGISTRAR 11-22-56 | | 24b. REGISTRAR'S SIGNATURE Wm. E. Russell | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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|---------------------|--|--------|--|--------|--|---------|--|---------------|--|-------------------|--|------------------|--|------------------|--|------------------|--|--------------------|--|--------------------|--|----------------------------|--|----------------------------|--|----------------------------|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | | 4. RACE | | 5. OCCUPATION | | 6. PLACE OF BIRTH | | 7. DATE OF BIRTH | | 8. DATE OF DEATH | | 9. TIME OF DEATH | | 10. CAUSE OF DEATH | | 11. PLACE OF DEATH | | 12. SIGNATURE OF PHYSICIAN | | 13. SIGNATURE OF REGISTRAR | | 14. SIGNATURE OF WITNESSES | |
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11583 CERTIFICATE OF DEATH

Reg. Dist. No. 216

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|---|---------------------------|--|---------------------------------------|--|--|--|---|
| 1. PLACE OF DEATH
o. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>md.</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | | | c. LENGTH OF STAY IN 1b <u>48 days</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Alta Vista Rest Home</u> | | | | d. STREET ADDRESS <u>4819 North Lane</u> | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Andrew</u> Middle <u>Phillips</u> Last <u>Phillips</u> | | | | 4. DATE OF DEATH Month <u>Nov.</u> Day <u>18</u> Year <u>1956</u> | | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Mar. 11, 1870</u> | 9. AGE (In years last birthday) <u>86</u> yrs. | IF UNDER 1 YEAR Months <u>8</u> Days <u>7</u> Hours <u></u> Min. <u></u> | | IF UNDER 24 HRS. Hours <u></u> Min. <u></u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Landscape Gardener-Contr. Gardener</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u> | | 11. BIRTHPLACE (State or foreign country) <u>U.S.</u> | |
| 13. FATHER'S NAME <u>Naked Phillips</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Eliza Guislippie</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>---</u> | | | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT Address <u>Mildred C Phillips</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardio-respiratory failure</u>
<u>450.0</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>congestive heart failure</u>
DUE TO (c) <u>arterio-sclerosis + senility</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>3 min.</u>
<u>7 days</u>
<u>20 yrs.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>senility</u> | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. <u>19</u> p. m. <u></u> | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from <u>1953</u> , 19 <u>56</u> , to <u>18 Nov</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>14 Nov</u> , 19 <u>56</u> , and that death occurred at <u>10:55 A</u> M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) <u>Bethesda 14, Maryland</u> DATE SIGNED <u>7659 Georgetown Rd.</u> | | | | | | | |
| ACTUAL SIGNATURE <u>John M Wyman</u> M.D. <u>7659 Georgetown Rd.</u> | | | | PHYSICIAN'S NAME (Type) <u>John M. Wyman</u> <u>Bethesda 14, Maryland</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>11-20-1956</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Cem.</u> | | 22d. LOCATION (City, town, or county) (State) <u>Montgomery Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda Md</u> | | | | 24a. REC'D BY REGISTRAR <u>DATE-20-56</u> | | 24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2, should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MAINTAIN STATE DEPARTMENT OF HEALTH—BALTIMORE, MD

BUREAU V. S.

NOV 26 1930

RECEIVED

| | | | |
|------------------------------------|--|---------------------------------|--|
| NAME OF DECEASED
JAMES EARL RAY | | SEX
Male | |
| DATE OF BIRTH
JAN 22 1912 | | PLACE OF BIRTH
MOBILE, ALA | |
| OCCUPATION
None | | MARITAL STATUS
Single | |
| STREET ADDRESS
1000 1st St S | | CITY
MOBILE | |
| COUNTY
MOBILE | | STATE
ALA | |
| DATE OF DEATH
NOV 26 1930 | | TIME OF DEATH
10:00 AM | |
| PLACE OF DEATH
Home | | CAUSE OF DEATH
Heart Disease | |
| MEDICAL HISTORY
None | | MANNER OF DEATH
Natural | |
| SIGNATURE OF DECEASED
None | | SIGNATURE OF WITNESS
None | |
| SIGNATURE OF PHYSICIAN
None | | SIGNATURE OF CORONER
None | |

11524 CERTIFICATE OF DEATH

Reg. Dist. No. 216

| | | | |
|--|----------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Washington b. COUNTY District of Columbia | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Kensington | | c. LENGTH OF STAY IN 1b
6 months | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Kensington Gardens | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Washington | |
| | | d. STREET ADDRESS
1301 Longfellow St. N. W. | |
| 3. NAME OF DECEASED (Type or print)
First Harry Middle Murray Last PHILLIPS | | 4. DATE OF DEATH
Month November Day 23 Year 19 56 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Sept. 22, 1876 |
| 9. AGE (In years last birthday)
80 yrs. | | IF UNDER 1 YEAR: Months 2 Days 1 Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Ret. - Meat & Prov. | | 10b. KIND OF BUSINESS OR INDUSTRY
Henry's Mkt. - D. C. | |
| 11. BIRTHPLACE (State or foreign country)
Washington, D. C. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Joseph Phillips | | 14. MOTHER'S MAIDEN NAME
Martha Klopfer | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
579-07-6917 | |
| 17. INFORMANT
Philip C. McCurdy-10311 Detrick Ave. Kens. Md | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive Heart Failure
450.0 DUE TO arteriosclerosis, Generalized -
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO Senility
(b) Senility
(c) | | INTERVAL BETWEEN ONSET AND DEATH
1 day
hrs
hrs. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. 19
p. m. | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 9/15/56 , 19 56 , to 11/23/56 , 19 56 , that I last saw the deceased alive on 11-23/56 , 19 56 , and that death occurred at 8:48 P.M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) Kensington, Md DATE SIGNED 11/23/56 | | | |
| ACTUAL SIGNATURE Sam Allen M.D. | | PHYSICIAN'S NAME (Type) JAM Allen, M.D. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
11/26/1956 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Cedar Hill | | 22d. LOCATION (City, town, or county) (State)
Prince Georges Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Robert A. Pumphrey-7557 Wis. Ave. Beth. Md. | | ADDRESS | |
| 24a. REC'D BY REGISTRAR
DATE 1-27-56 | | 24b. REGISTRAR'S SIGNATURE
Beattie M. Thompson | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

NOTES

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(C) 1987

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Keweenaw Avenue

DATE _____

Received 10 October 1987; accepted 16 November 1987

VOLUME 13 NUMBER 1 - 1991

Martin Klover

John S. H. H. H.

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BUREAU V. B.

NOV 28 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11585 CERTIFICATE OF DEATH

Reg. Dist. No.

11560216

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <input checked="" type="checkbox"/>
a. STATE Virginia b. COUNTY Prince William | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda | | c. LENGTH OF STAY IN 1b
18 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
The Clinical Center, Bethesda 14, Md. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Manassas | |
| 3. NAME OF DECEASED (Type or print)
First Eleanor Middle Louise Last Pickett | | 4. DATE OF DEATH
Month November Day 5 Year 1956 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
October 13, 1911 |
| 9. AGE (In years last birthday)
45 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS.
Months 0 Days 22 Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Typist | | 10b. KIND OF BUSINESS OR INDUSTRY
Unknown | |
| 11. BIRTHPLACE (State or foreign country)
Kansas | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
Henry Luker | | 14. MOTHER'S MAIDEN NAME
Marie Hellmann | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
Unknown | |
| 17. INFORMANT The Medical Record Address
The Clinical Center, Bethesda 14, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory obstruction & anoxia
170X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) metastatic breast carcinoma
DUE TO
(c) | | INTERVAL BETWEEN ONSET AND DEATH
minute
1 yr. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. p. m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
of work of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from October 18, 1956 , to November 5, 1956 , that I last saw the deceased alive on November 5, 1956 , and that death occurred at 6:54 P. , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE L. Weissman M.D. | | ADDRESS (Street, city or town, state) The Clinical Center
DATE SIGNED 11/6/56 | |
| PHYSICIAN'S NAME (Type) S. Weissman, M. D. | | National Institutes of Health
Bethesda 14, Maryland | |
| 22a. BURIAL, CREMATION, or REBURYAL (Specify)
buried | | 22b. DATE THEREOF
Nov. 5, 1956 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Luthuen Cem. | | 22d. LOCATION (City, town, or county) (State)
Manassas Va. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
GEORGE D. BAKER & SON-Manassas, Virginia | | 24a. REC'D BY REGISTRAR
NOV 7 1956 | |
| 24b. REGISTRAR'S SIGNATURE
Bessie Thompson | | | |

11586 CERTIFICATE OF DEATH

Reg. Dist. No. 211

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Damascus | | c. LENGTH OF STAY IN 1b
28 years | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS | |
| 3. NAME OF DECEASED
(Type or print)
First Olea Middle -- Last Furdum | | 4. DATE OF DEATH
Month November Day 24 Year 19 56 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Sept. 27, 1882 |
| 9. AGE (In years last birthday)
74 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
Own home | |
| 11. BIRTHPLACE (State or foreign country)
New Market, Md. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Frank Burdette | | 14. MOTHER'S MAIDEN NAME
Columbia Burdette | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) no
(If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
Mr. Urner S. Purdum, Damascus, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Coronary Occlusion
420.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Sclerosis
DUE TO General Arteriosclerosis
(c) | | | INTERVAL BETWEEN ONSET AND DEATH
1 hour

?
? |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Osteo-arthritis | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. 11 p. m. 19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from March 1951 to November 24, 1956 and that I last saw the deceased alive on November 24, 1956 , and that death occurred at 12:07 AM from the causes and on the date stated above.
ADDRESS (Street, city or town, state) Druid Theatre Building DATE SIGNED 11-25-56
ACTUAL SIGNATURE M. McKendree Boyer M.D. Damascus, Maryland.
PHYSICIAN'S NAME (Type) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
Nov. 26, 1956 | 22c. NAME OF CEMETERY OR CREMATORY
Providence Cemetery | 22d. LOCATION (City, town, or county) (State)
Kempton, Maryland. |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Oliver L. Molesworth | | ADDRESS
Damascus, Md. | 24a. REC'D BY REGISTRAR
DATE Nov 26/56 |
| | | 24b. REGISTRAR'S SIGNATURE
Della W. Burdette | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

715

BUREAU V. S.

NOV 27 1956

RECEIVED

11587

CERTIFICATE OF DEATH

Reg. Dist. No.

216

| | | | |
|---|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>md.</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> 14 house | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u> | | d. STREET ADDRESS <u>707 Stonestreet ave</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Debra Dorspelle Randolph</u> | | 4. DATE OF DEATH <u>Nov. 20</u> 19 <u>56</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>negro</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>November 20, 1926</u> |
| 9. AGE (In years last birthday) <u>30</u> yrs. | | 10. IF UNDER 1 YEAR: Months <u>14</u> Days <u>14</u> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <u>md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>not given</u> | | 14. MOTHER'S MAIDEN NAME <u>Margaret Joanne Randolph</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <u>Mother</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Atherosclerosis</u>
<u>762.0</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____
DUE TO (c) _____ | | | INTERVAL BETWEEN ONSET AND DEATH <u>14 hours</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. _____ p. m. _____ 19 _____ | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) _____ (County) _____ (State) _____ |
| 21. I certify that I attended the deceased from <u>Nov 20, 1956</u> , to <u>Nov 20, 1956</u> , that I last saw the deceased alive on <u>Nov 20, 1956</u> , and that death occurred at <u>9:15 P.M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>John E. Cassidy</u> M.D. | | ADDRESS (Street, city or town, state) <u>9911 Old Georgetown Rd.</u> | |
| PHYSICIAN'S NAME (Type) <u>JOHN E. CASSIDY</u> | | DATE SIGNED <u>Bethesda, Maryland</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF <u>Nov. 22, 1956</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Park</u> | 22d. LOCATION (City, town, or county) (State) <u>Rockville, Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Swenson</u> | | 24a. REC'D BY REGISTRAR <u>Nov 27 1956</u> | |
| ADDRESS <u>Rockville, Md.</u> | | 24b. REGISTRAR'S SIGNATURE <u>Bessie Thompson</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2074171XVI

CERTIFICATE OF DEATH

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH
COUNTY | | 2. NAME OF DECEASED | |
| 3. CITY OR TOWN WHERE DECEASED | | 4. DATE OF DEATH | |
| 5. STREET ADDRESS | | 6. AGE | |
| 7. SEX | | 8. RACE | |
| 9. OCCUPATION | | 10. CAUSE OF DEATH | |
| 11. MEDICAL HISTORY | | 12. SIGNATURE OF PHYSICIAN | |
| 13. SIGNATURE OF REGISTRAR | | 14. SIGNATURE OF WITNESSES | |
| 15. SIGNATURE OF DECEASED | | 16. SIGNATURE OF NEXT OF KIN | |
| 17. SIGNATURE OF BURIAL OFFICIAL | | 18. SIGNATURE OF CHURCH OFFICIAL | |
| 19. SIGNATURE OF FUNERAL HOME | | 20. SIGNATURE OF CEMETERY | |
| 21. SIGNATURE OF HEALTH OFFICIAL | | 22. SIGNATURE OF COUNTY CLERK | |
| 23. SIGNATURE OF STATE DEPARTMENT OF HEALTH | | 24. SIGNATURE OF BALTIMORE CITY CLERK | |
| 25. SIGNATURE OF BALTIMORE CITY CLERK | | 26. SIGNATURE OF BALTIMORE CITY CLERK | |
| 27. SIGNATURE OF BALTIMORE CITY CLERK | | 28. SIGNATURE OF BALTIMORE CITY CLERK | |
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| 41. SIGNATURE OF BALTIMORE CITY CLERK | | 42. SIGNATURE OF BALTIMORE CITY CLERK | |
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| 55. SIGNATURE OF BALTIMORE CITY CLERK | | 56. SIGNATURE OF BALTIMORE CITY CLERK | |
| 57. SIGNATURE OF BALTIMORE CITY CLERK | | 58. SIGNATURE OF BALTIMORE CITY CLERK | |
| 59. SIGNATURE OF BALTIMORE CITY CLERK | | 60. SIGNATURE OF BALTIMORE CITY CLERK | |
| 61. SIGNATURE OF BALTIMORE CITY CLERK | | 62. SIGNATURE OF BALTIMORE CITY CLERK | |
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| 65. SIGNATURE OF BALTIMORE CITY CLERK | | 66. SIGNATURE OF BALTIMORE CITY CLERK | |
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| 95. SIGNATURE OF BALTIMORE CITY CLERK | | 96. SIGNATURE OF BALTIMORE CITY CLERK | |
| 97. SIGNATURE OF BALTIMORE CITY CLERK | | 98. SIGNATURE OF BALTIMORE CITY CLERK | |
| 99. SIGNATURE OF BALTIMORE CITY CLERK | | 100. SIGNATURE OF BALTIMORE CITY CLERK | |

RECEIVED
NOV 27 1956
BUREAU V. 3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11485 CERTIFICATE OF DEATH

11563

Reg. Dist. No.

| | | | |
|--|--|--|---|
| 1. PLACE OF DEATH
o. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rockville | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rockville | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
403 Woodburn Road | | d. STREET ADDRESS
403 Woodburn Road | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First James Middle E Last Redmond | | 4. DATE OF DEATH
Month November Day 11 Year 1956 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Feb. ? 1881 |
| 9. AGE (In years last birthday)
75 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Ret. Oiler-Cranes | | 10b. KIND OF BUSINESS OR INDUSTRY
Construction | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Unknown | | 14. MOTHER'S MAIDEN NAME
Unknown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) -- | | 16. SOCIAL SECURITY NO.
78-01-7033 | |
| 17. INFORMANT
Granddaughter | | Address 403 Woodburn Rd. Rockville, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Thrombosis
420.0 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Congestive heart failure
DUE TO (c) Arteriosclerotic Heart Disease | | INTERVAL BETWEEN ONSET AND DEATH
5-10
7-10
5? years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Nov. 2, 1956 to Nov. 11, 1956 , that I last saw the deceased alive on Nov. 10, 1956 , and that death occurred at 4:30 P.M. , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Thomas A. N. Hindman M.D. | | ADDRESS (Street, city or town, state) 3935 Baltimore St. DATE SIGNED 11/11/56 | |
| PHYSICIAN'S NAME (Type) Thomas A. N. Hindman | | Kousungton Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
11-14-1956 | 22c. NAME OF CEMETERY OR CREMATORY
Washington Nat. Cem. | 22d. LOCATION (City, town, or county) (State)
Suitland Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Robert A. Pumphrey | | ADDRESS
Bethesda, Md. | |
| 24a. REC'D BY REGISTRAR
DATE 11/14/56 | | 24b. REGISTRAR'S SIGNATURE
Laurel Kragtorp | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 16 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11496

CERTIFICATE OF DEATH

11564

Reg. Dist. No.

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission)
a. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rockville | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rockville | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
104 S. Adams Street | | d. STREET ADDRESS
104 S. Adams St. | |
| 3. NAME OF DECEASED (Type or print)
THEODORE A RICKETTS | | 4. DATE OF DEATH
Month November Day 8 Year 19 56 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Feb. 1-1896 |
| 9. AGE (In years last birthday)
60 yrs. | | IF UNDER 1 YEAR
Months 9 Days 7
IF UNDER 24 HRS.
Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Asst. Post Master | | 10b. KIND OF BUSINESS OR INDUSTRY
US GOVT. | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Wallace E. Ricketts | | 14. MOTHER'S MAIDEN NAME
Emma L. Mullican | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)
Yes | | 16. SOCIAL SECURITY NO.
UnkNown | |
| 17. INFORMANT
Wife | | Address 104 S. Adams St. Rockville Md | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CEREBRAL METASTASIS
162x
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) BRONCHIOGENIC CARCINOMA
DUE TO
(c) | | INTERVAL BETWEEN ONSET AND DEATH
24 HOURS
4 MONTHS | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
HYPERTENSIVE ARTERIOSCLEROTIC HEART DISEASE | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from AUGUST 3, 1956 to NOVEMBER 8, 1956 , that I last saw the deceased alive on NOVEMBER 6, 1956 , and that death occurred at 8:15 P.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
Gordon S. Rosenberger M.D. | | ADDRESS (Street, city or town, state)
310 W. Montgomery Ave. Rockville, Md. | |
| PHYSICIAN'S NAME (Type)
Gordon S. Rosenberger | | DATE SIGNED
Nov. 8, 1956 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
11-10-1956 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Parklawn | | 22d. LOCATION (City, town, or county) (State)
Montgomery Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Robert A. Pumphrey | | ADDRESS
Bethesda, Md | |
| 24a. REC'D BY REGISTRAR
DATE 11/13/56 | | 24b. REGISTRAR'S SIGNATURE
Laurel Kragtorp | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Page One of One

| | | | | | | | | | | | | | | | |
|-------------------|--|--------------------|--|-----------|--|---------------|--|----------------|--|----------------|--|--------------------|--|---------------------------------|--|
| NAME OF DECEASED | | SEX | | AGE | | DATE OF BIRTH | | PLACE OF BIRTH | | CITY | | STATE | | COUNTRY | |
| JAMES EARL RAY | | MALE | | 35 | | JAN 5 1928 | | MOBILE | | ALABAMA | | UNITED STATES | | UNITED STATES | |
| RACE | | COLOR | | RELIGION | | MARRIAGE | | EDUCATION | | OCCUPATION | | SPECIAL OCCUPATION | | MILITARY SERVICE | |
| WHITE | | WHITE | | METHODIST | | MARRIED | | HIGH SCHOOL | | BUSINESS MAN | | NONE | | NONE | |
| DATE OF DEATH | | PLACE OF DEATH | | CITY | | STATE | | COUNTRY | | CAUSE OF DEATH | | MANNER OF DEATH | | MEDICAL ATTENDANT | |
| APR 4 1968 | | MEMPHIS | | TENNESSEE | | UNITED STATES | | UNITED STATES | | HEART DISEASE | | SUICIDE | | DR. J. W. HARRIS | |
| DATE OF REPORT | | PLACE OF REPORT | | CITY | | STATE | | COUNTRY | | REPORTED BY | | TITLE | | INSTITUTION | |
| APR 10 1968 | | MEMPHIS | | TENNESSEE | | UNITED STATES | | UNITED STATES | | F. B. I. | | SPECIAL AGENT | | FEDERAL BUREAU OF INVESTIGATION | |
| DATE OF INTERVIEW | | PLACE OF INTERVIEW | | CITY | | STATE | | COUNTRY | | INTERVIEWED BY | | TITLE | | INSTITUTION | |
| APR 10 1968 | | MEMPHIS | | TENNESSEE | | UNITED STATES | | UNITED STATES | | F. B. I. | | SPECIAL AGENT | | FEDERAL BUREAU OF INVESTIGATION | |
| DATE OF SIGNATURE | | PLACE OF SIGNATURE | | CITY | | STATE | | COUNTRY | | SIGNED BY | | TITLE | | INSTITUTION | |
| APR 10 1968 | | MEMPHIS | | TENNESSEE | | UNITED STATES | | UNITED STATES | | F. B. I. | | SPECIAL AGENT | | FEDERAL BUREAU OF INVESTIGATION | |

BUREAU V. 2

NOV 15 1956

RECEIVED

11588 CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|-------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>Hansington Gardens Sanitarium</u> | | d. STREET ADDRESS
<u>3000 McComas Ave.</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Loretta M. Rinehart</u> | | 4. DATE OF DEATH <u>November 15 1956</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>June 25 1878</u> yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>at home</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country)
<u>Washington D.C.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.</u> | |
| 13. FATHER'S NAME
<u>John Smith</u> | | 14. MOTHER'S MAIDEN NAME
<u>Barbara Gohsenreiter</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
<u>JAMES RINEHART</u> | | Address
<u>13309 Okinawa Ave
Rockville Md.</u> | |

| | | |
|---|--|--|
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Left Ventricular Failure</u>
DUE TO
<u>443X</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) <u>Hypertensive Cardiovascular Disease</u>
DUE TO
(c) <u>2 years</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>2 weeks</u> |
|---|--|--|

| | | |
|--|--|---|
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>Cerebral Vascular Accident</u> | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
|--|--|---|

| | | | |
|--|--|--|--|
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u>~~~~~</u> | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. <u>~~~~~</u> 19
p. m. <u>~~~~~</u> | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u>~~~~~</u> | 20f. (City or town) (County) (State)
<u>~~~~~</u> |

| | |
|---|--|
| 21. I certify that I attended the deceased from <u>Aug. 10</u> , 1956, to <u>Nov. 15</u> , 1956, that I last saw the deceased alive on <u>Nov. 1</u> , 1956, and that death occurred at <u>11:45 A.M.</u> , from the causes and on the date stated above. | |
| ACTUAL SIGNATURE <u>James L. Laubach</u> M.D. | ADDRESS (Street, city or town, state) <u>1806 Fox St. Hyattsville, Md.</u> |
| PHYSICIAN'S NAME (Type) <u>James L. Laubach</u> | DATE SIGNED <u>Nov. 15 1956</u> |

| | | | |
|--|--------------------------------------|--|---|
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 22b. DATE THEREOF
<u>11/19/56</u> | 22c. NAME OF CEMETERY OR CREMATORY
<u>George Washington Cemetery, Hyattsville Md.</u> | 22d. LOCATION (City, town, or county) (State)
<u>Hyattsville Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Frank Levers, Sons Co</u> | | ADDRESS
<u>3605-14 St NW</u> | 24a. REC'D BY REGISTRAR
<u>NOV 16 1956</u> |
| | | 24b. REGISTRAR'S SIGNATURE
<u>A. H. Hedrick</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—SALMONELLA 18

1956 16 Nov

RECEIVED

11589

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11566

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 216

| | | | | | | | |
|---|--|---|------------------------------------|---|---|---|---|
| 1. PLACE OF DEATH
o. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
o. STATE Maryland b. COUNTY Montg. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda | | c. LENGTH OF STAY IN 1b
7 hrs. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Suburban Hosp. | | | | d. STREET ADDRESS
5021 Bradley Boulevard | | | |
| 3. NAME OF DECEASED (Type or print)
First Delmas Middle Lee Last Rolland | | | | 4. DATE OF DEATH
Month 11 Day 4 Year 1956 | | | |
| 5. SEX
male | 6. COLOR OR RACE
white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
5/10/37 | 9. AGE (In years last birthday)
19 yrs. | IF UNDER 1 YEAR
Months 5 Days 14 | IF UNDER 24 HRS.
Hours 8 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
machinist | | 10b. KIND OF BUSINESS OR INDUSTRY
R.E. Darling Comp. | | 11. BIRTHPLACE (State or foreign country)
Va. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Delmas Joe Rolland | | | | 14. MOTHER'S MAIDEN NAME
Ruth Lee Adams | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
877-50-4222 | | 17. INFORMANT
Linda (wife) Same as Item 2 | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral hemorrhage and laceration
DUE TO Fracture of skull
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) 825x
(c) 8 hrs | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
8 hrs |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Was passenger in auto involved in accident | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
3:20 a.m. 11/4/56 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
street | | 20f. (City or town)
Bethesda | | (County) Mont. (State) Md. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE
Frank J. Broschart | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type)
Frank J. Broschart | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
11-6-56 | | 22c. NAME OF CEMETERY OR CREMATORY
Parklawn Cemetery | | 22d. LOCATION (City, town, or county) (State)
Montgomery Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Robert A. Pumphrey | | | | ADDRESS
Bethesda Md | | 24a. REC'D BY REGISTRAR
DATE 11-9-56 | |
| | | | | 24b. REGISTRAR'S SIGNATURE
Bessie M. Thompson | | | |

MEDICAL CERTIFICATION

15

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained for the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | | | |
|-----------------------|--|-------------------|--|---------------------|--|---------------------|--|----------------------|--|----------------|--|-------------|--|----------------|--|---------------|--|
| NAME OF DECEASED | | AGE | | SEX | | RACE | | DATE OF BIRTH | | PLACE OF BIRTH | | CITY | | STATE | | COUNTRY | |
| FATHER'S NAME | | MOTHER'S NAME | | MARRIED | | SINGLE | | WIDOWED | | DIVORCED | | MARRIED | | SINGLE | | WIDOWED | |
| OCCUPATION | | EDUCATION | | RELIGION | | POLITICAL PARTY | | MILITARY SERVICE | | NATIONALITY | | CITIZENSHIP | | RESIDENCE | | DATE OF DEATH | |
| CAUSE OF DEATH | | MANNER OF DEATH | | PLACE OF DEATH | | DATE OF DEATH | | TIME OF DEATH | | TEMPERATURE | | PULSE | | BLOOD PRESSURE | | WEIGHT | |
| SIGNATURE OF EXAMINER | | TITLE OF EXAMINER | | DATE OF EXAMINATION | | TIME OF EXAMINATION | | PLACE OF EXAMINATION | | CITY | | STATE | | COUNTRY | | REMARKS | |

BUREAU V. S.

NOV 13 1956

RECEIVED

ORIGINAL FILED IN

11477 CERTIFICATE OF DEATH

Reg. Dist. No. 223

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH
o. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> | | | | c. LENGTH OF STAY in 1b <u>1 week</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium Hospital</u> | | | | d. STREET ADDRESS <u>1908 Amherst Rd</u> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Ellen Loretta Ryan</u> | | | | 4. DATE OF DEATH <u>Nov 5 1956</u> | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>cauc</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Oct 2, 1883</u> | |
| 9. AGE (In years last birthday) <u>73</u> yrs. | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>New York</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>John Reynolds</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Mary Ottenberg</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Me Wm Ryan</u> | | Address <u>Same</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>acute Coronary Occlusion</u>
<u>420.1</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary artery Heart Disease</u>
DUE TO (c) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>appr 3 years</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Jan 4 1954</u> to <u>Nov 5 1956</u> that I last saw the deceased alive on <u>Nov 5 1956</u> and that death occurred at <u>7:40 PM</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Wayne Bluckfield</u> | | | | ADDRESS (Street, city or town, state) <u>6826 Sigg Rd Hyattsville Md</u> | | | |
| PHYSICIAN'S NAME (Type) <u>H WAYNE BLUCKFIELD M.D.</u> | | | | DATE SIGNED | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| <u>Transit Burial</u> | | <u>Nov 9, 1956</u> | | <u>Flushing Cemetery</u> | | <u>Long Island, New York</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u> | | | | ADDRESS <u>254 Carroll St NW DC</u> | | 24a. REC'D BY REGISTRAR | |
| | | | | DATE <u>11/7/56</u> | | 24b. REGISTRAR'S SIGNATURE <u>J. Arthur Walters</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

NOV 8 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11590

CERTIFICATE OF DEATH

11568

Reg. Dist. No.

2/7

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney | | | | c. LENGTH OF STAY IN 1b 2 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg, Md. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) Montgomery Co. General Hospital, Inc. | | | | d. STREET ADDRESS | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Rosemary Middle Louise Last Santos | | | | 4. DATE OF DEATH
Month November Day 19 Year 1956 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 7/5/54 | |
| 9. AGE (In years last birthday) 2 yrs. | | IF UNDER 1 YEAR
Months 2 Days 19 Hours 56 Min. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME Joseph Frances Santos | | | | 14. MOTHER'S MAIDEN NAME Gladys Lorraine Merrick | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | | 17. INFORMANT Mother | | Address Rt. 1, Gaithersburg, Md | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute tracheo-bronchitis
500x DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Laryngeal obstruction DUE TO
(c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH
3 days
1 day | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
11/19/56 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 11/17/56 to 11/19/56 that I last saw the deceased alive on 11/19/56 , and that death occurred at 1:55 p.m. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE [Signature] | | | | ADDRESS (Street, city or town, state) Sandy Sp. 7 Md | | DATE SIGNED 11/19/56 | |
| PHYSICIAN'S NAME (Type) | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF Nov 21/56 | | 22c. NAME OF CEMETERY OR CREMATORY Goshen Md | | 22d. LOCATION (City, town, or county) (State) Montgomery Co Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Roy W Barber Gaithersburg | | | | 24a. REC'D BY REGISTRAR 11-22-56 | | 24b. REGISTRAR'S SIGNATURE [Signature] | |

515

BUREAU V. S.

1956 23 NOV

RECEIVED

11478 CERTIFICATE OF DEATH

11569

Reg. Dist. No. 223

| | | | |
|--|---------------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> | | c. LENGTH OF STAY IN 1b <u>2 days</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. San. + Hospital</u> | | d. STREET ADDRESS <u>912 Patton Dr.</u> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Sawyer</u> First <u>Willard</u> Middle <u>Spear</u> Last <u>Sawyer</u> | | 4. DATE OF DEATH Month <u>11</u> - Day <u>5</u> - Year <u>1956</u> | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>8-15-95</u> |
| 9. AGE (In years last birthday) <u>61</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>school teacher</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <u>N. Y.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>America</u> | |
| 13. FATHER'S NAME <u>Willard S. Sawyer</u> | | 14. MOTHER'S MAIDEN NAME <u>Lida Cotton</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>W.W.I</u> | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <u>Wash. San. + Hosp. Records</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Myocardial Failure</u>
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Acute Anterior Coronary Artery Occlusion</u>
DUE TO (c) <u>Generalized arteriosclerosis</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>4 days</u>
<u>years</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>9-12, 1945</u> , to <u>11-5, 1956</u> , that I last saw the deceased alive on <u>11-5, 1956</u> , and that death occurred at <u>4:53 P.M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Med Phema W.D.</u> M.D. <u>8005 Verrington Rd</u> | | DATE SIGNED <u>11-5-56</u> | |
| PHYSICIAN'S NAME (Type) <u>NC SHOEMAKER, M.D.</u> | | <u>Silver Spring, Md</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>Nov. 8, 1956</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u> | 22d. LOCATION (City, town, or county) (State) <u>Arlington Virginia</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u> ADDRESS <u>254 Carroll Pl NW. DC</u> | | 24a. REC'D BY REGISTRAR DATE <u>11/7/56</u> | |
| | | 24b. REGISTRAR'S SIGNATURE <u>J. William Deak</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | |
|--|--|--|--|
| 1. NAME OF DECEASED
<i>William Miller</i> | | 2. SEX
<i>Male</i> | |
| 3. AGE
<i>21</i> | | 4. DATE OF BIRTH
<i>8-12-92</i> | |
| 5. PLACE OF BIRTH
<i>W. Va.</i> | | 6. OCCUPATION
<i>Student</i> | |
| 7. MARITAL STATUS
<i>Single</i> | | 8. CAUSE OF DEATH
<i>Heart Disease</i> | |
| 9. DATE OF DEATH
<i>11-3-22</i> | | 10. PLACE OF DEATH
<i>Home</i> | |
| 11. SIGNATURE OF PHYSICIAN
<i>[Signature]</i> | | 12. SIGNATURE OF REGISTRAR
<i>[Signature]</i> | |

BUREAU V. S.

NOV 3 1922

RECEIVED

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11591

CERTIFICATE OF DEATH

Reg. Dist. No.

11570
217

| | | | | | | | |
|---|----------------------------------|---|------------------------------------|---|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Olney | | | | c. LENGTH OF STAY IN 1b
52 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Montgomery County General Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| d. STREET ADDRESS
1219 Rockville Pike | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
First William Middle Scherrer Last Scherrer | | | | 4. DATE OF DEATH
Month November Day 5 Year 19 56 | | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
8/24/60 | | 9. AGE (In years last birthday)
96 yrs. | IF UNDER 1 YEAR
Months 96 | IF UNDER 24 HRS.
Days 96 Hours 96 Min. 96 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Phillip Scherrer | | | | 14. MOTHER'S MAIDEN NAME
Christine | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
(If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Hospital Record (Daughter) | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic Angestive Heart Failure
450.0 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 940.9 (b) Generalized Arteriosclerosis DUE TO
(c) unbecomg | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
4 weeks |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Fracture of Rt. Hip - about 6 weeks prior to death | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY Month, Day, Year
Hour a. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) | | (State) | |
| 21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 3:48 A.M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ | | | | | | | |
| ACTUAL SIGNATURE Arthur F. Woodward M.D. _____ | | | | | | | |
| PHYSICIAN'S NAME (Type) Arthur F. Woodward, M. D. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
Nov. 8, 1956 | | 22c. NAME OF CEMETERY OR CREMATORY
St. Marys Cemetery | | 22d. LOCATION (City, town, or county) (State)
Rockville, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Robert A. Pennington | | ADDRESS
Bethesda, Md. | | 24a. REC'D BY REGISTRAR
DATE 11-7-56 | | 24b. REGISTRAR'S SIGNATURE
Gertrude Lawler | |

CERTIFICATE OF DEATH

| | | | | | |
|---|--|---|--|---|--|
| 1. NAME OF DECEASED
<i>JOHN J. ROBERTS</i> | | 2. SEX
<i>Male</i> | | 3. AGE
<i>45</i> | |
| 4. DATE OF DEATH
<i>Nov 12 1956</i> | | 5. TIME OF DEATH
<i>10:30 AM</i> | | 6. PLACE OF DEATH
<i>Home</i> | |
| 7. CAUSE OF DEATH
<i>Myocardial Infarction</i> | | 8. MANNER OF DEATH
<i>Natural</i> | | 9. PLACE OF BIRTH
<i>Baltimore, Md.</i> | |
| 10. DATE OF BIRTH
<i>Nov 12 1911</i> | | 11. TIME OF BIRTH
<i>10:30 AM</i> | | 12. PLACE OF BIRTH
<i>Baltimore, Md.</i> | |
| 13. NAME OF FATHER
<i>John J. Roberts</i> | | 14. NAME OF MOTHER
<i>Elizabeth Roberts</i> | | 15. NAME OF SPOUSE
<i>Elizabeth Roberts</i> | |
| 16. NAME OF DECEASED
<i>John J. Roberts</i> | | 17. NAME OF DECEASED
<i>John J. Roberts</i> | | 18. NAME OF DECEASED
<i>John J. Roberts</i> | |
| 19. NAME OF DECEASED
<i>John J. Roberts</i> | | 20. NAME OF DECEASED
<i>John J. Roberts</i> | | 21. NAME OF DECEASED
<i>John J. Roberts</i> | |
| 22. NAME OF DECEASED
<i>John J. Roberts</i> | | 23. NAME OF DECEASED
<i>John J. Roberts</i> | | 24. NAME OF DECEASED
<i>John J. Roberts</i> | |
| 25. NAME OF DECEASED
<i>John J. Roberts</i> | | 26. NAME OF DECEASED
<i>John J. Roberts</i> | | 27. NAME OF DECEASED
<i>John J. Roberts</i> | |
| 28. NAME OF DECEASED
<i>John J. Roberts</i> | | 29. NAME OF DECEASED
<i>John J. Roberts</i> | | 30. NAME OF DECEASED
<i>John J. Roberts</i> | |
| 31. NAME OF DECEASED
<i>John J. Roberts</i> | | 32. NAME OF DECEASED
<i>John J. Roberts</i> | | 33. NAME OF DECEASED
<i>John J. Roberts</i> | |
| 34. NAME OF DECEASED
<i>John J. Roberts</i> | | 35. NAME OF DECEASED
<i>John J. Roberts</i> | | 36. NAME OF DECEASED
<i>John J. Roberts</i> | |
| 37. NAME OF DECEASED
<i>John J. Roberts</i> | | 38. NAME OF DECEASED
<i>John J. Roberts</i> | | 39. NAME OF DECEASED
<i>John J. Roberts</i> | |
| 40. NAME OF DECEASED
<i>John J. Roberts</i> | | 41. NAME OF DECEASED
<i>John J. Roberts</i> | | 42. NAME OF DECEASED
<i>John J. Roberts</i> | |
| 43. NAME OF DECEASED
<i>John J. Roberts</i> | | 44. NAME OF DECEASED
<i>John J. Roberts</i> | | 45. NAME OF DECEASED
<i>John J. Roberts</i> | |
| 46. NAME OF DECEASED
<i>John J. Roberts</i> | | 47. NAME OF DECEASED
<i>John J. Roberts</i> | | 48. NAME OF DECEASED
<i>John J. Roberts</i> | |
| 49. NAME OF DECEASED
<i>John J. Roberts</i> | | 50. NAME OF DECEASED
<i>John J. Roberts</i> | | 51. NAME OF DECEASED
<i>John J. Roberts</i> | |
| 52. NAME OF DECEASED
<i>John J. Roberts</i> | | 53. NAME OF DECEASED
<i>John J. Roberts</i> | | 54. NAME OF DECEASED
<i>John J. Roberts</i> | |
| 55. NAME OF DECEASED
<i>John J. Roberts</i> | | 56. NAME OF DECEASED
<i>John J. Roberts</i> | | 57. NAME OF DECEASED
<i>John J. Roberts</i> | |
| 58. NAME OF DECEASED
<i>John J. Roberts</i> | | 59. NAME OF DECEASED
<i>John J. Roberts</i> | | 60. NAME OF DECEASED
<i>John J. Roberts</i> | |
| 61. NAME OF DECEASED
<i>John J. Roberts</i> | | 62. NAME OF DECEASED
<i>John J. Roberts</i> | | 63. NAME OF DECEASED
<i>John J. Roberts</i> | |
| 64. NAME OF DECEASED
<i>John J. Roberts</i> | | 65. NAME OF DECEASED
<i>John J. Roberts</i> | | 66. NAME OF DECEASED
<i>John J. Roberts</i> | |
| 67. NAME OF DECEASED
<i>John J. Roberts</i> | | 68. NAME OF DECEASED
<i>John J. Roberts</i> | | 69. NAME OF DECEASED
<i>John J. Roberts</i> | |
| 70. NAME OF DECEASED
<i>John J. Roberts</i> | | 71. NAME OF DECEASED
<i>John J. Roberts</i> | | 72. NAME OF DECEASED
<i>John J. Roberts</i> | |
| 73. NAME OF DECEASED
<i>John J. Roberts</i> | | 74. NAME OF DECEASED
<i>John J. Roberts</i> | | 75. NAME OF DECEASED
<i>John J. Roberts</i> | |
| 76. NAME OF DECEASED
<i>John J. Roberts</i> | | 77. NAME OF DECEASED
<i>John J. Roberts</i> | | 78. NAME OF DECEASED
<i>John J. Roberts</i> | |
| 79. NAME OF DECEASED
<i>John J. Roberts</i> | | 80. NAME OF DECEASED
<i>John J. Roberts</i> | | 81. NAME OF DECEASED
<i>John J. Roberts</i> | |
| 82. NAME OF DECEASED
<i>John J. Roberts</i> | | 83. NAME OF DECEASED
<i>John J. Roberts</i> | | 84. NAME OF DECEASED
<i>John J. Roberts</i> | |
| 85. NAME OF DECEASED
<i>John J. Roberts</i> | | 86. NAME OF DECEASED
<i>John J. Roberts</i> | | 87. NAME OF DECEASED
<i>John J. Roberts</i> | |
| 88. NAME OF DECEASED
<i>John J. Roberts</i> | | 89. NAME OF DECEASED
<i>John J. Roberts</i> | | 90. NAME OF DECEASED
<i>John J. Roberts</i> | |
| 91. NAME OF DECEASED
<i>John J. Roberts</i> | | 92. NAME OF DECEASED
<i>John J. Roberts</i> | | 93. NAME OF DECEASED
<i>John J. Roberts</i> | |
| 94. NAME OF DECEASED
<i>John J. Roberts</i> | | 95. NAME OF DECEASED
<i>John J. Roberts</i> | | 96. NAME OF DECEASED
<i>John J. Roberts</i> | |
| 97. NAME OF DECEASED
<i>John J. Roberts</i> | | 98. NAME OF DECEASED
<i>John J. Roberts</i> | | 99. NAME OF DECEASED
<i>John J. Roberts</i> | |
| 100. NAME OF DECEASED
<i>John J. Roberts</i> | | 101. NAME OF DECEASED
<i>John J. Roberts</i> | | 102. NAME OF DECEASED
<i>John J. Roberts</i> | |

BUREAU V. S.

NOV 14 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11592 CERTIFICATE OF DEATH

11571

Reg. Dist. No. 2/16

| | | | | | | | |
|--|-------------------------------|--|-------------------------------------|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Pennsylvania b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bridgeport | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center
National Institutes of Health, Bethesda, Md. | | | | d. STREET ADDRESS Boroline Road | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) | | First Robert Middle Richard Last Searfoss | | 4. DATE OF DEATH | | Month November Day 11 Year 1956 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 23 May 1937 | | 9. AGE (In years last birthday) 19 yrs. | IF UNDER 1 YEAR: Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier | | 10b. KIND OF BUSINESS OR INDUSTRY U.S. Air Force | | 11. BIRTHPLACE (State or foreign country) Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME George Searfoss | | | | 14. MOTHER'S MAIDEN NAME Elsie Beech | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) Currently | | 16. SOCIAL SECURITY NO. 181-69-1961 | | 17. INFORMANT The Medical Record, Clinical Center Address National Institutes of Health, Bethesda 14, M d. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial infarction with coronary
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from August 10, 1956 to November 11, 1956 , that I last saw the deceased alive on November 11, 1956 , and that death occurred at 6:15 P.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Thomas Waldmann M.D. | | | | ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 11/12/56 | | | |
| PHYSICIAN'S NAME (Type) Thomas Waldmann, M.D. | | | | National Institutes of Health, Bethesda, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 11-15-56 | | 22c. NAME OF CEMETERY OR CREMATORY Valley Forge Gardens | | 22d. LOCATION (City, town, or county) (State) Montgomery Co., Pennsylvania | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md. ADDRESS | | | | 24a. REC'D BY REGISTRAR DATE 1-13-56 | | 24b. REGISTRAR'S SIGNATURE Basia M. Henshaw | |

BUREAU V. S.

NOV 15 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Chief Medical Examiner's Office along with form PM3. Page 3 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

| MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 | | | | | | | | | | | |
|--|--|---|--|---|--|--|---|---|--|--|--|
| Items 18&21 Film 208 12-12-56 ems | | | | | | | | | | | |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
| Reg. Dist. No. 276 | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda | | | c. LENGTH OF STAY IN 1b
D.O.A. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Suburban Hos p | | | | | d. STREET ADDRESS
9525 Sedberry Ewing Dr. | | | | | | |
| 3. NAME OF DECEASED (Type or print)
Charles P. Sedberry | | | | | 4. DATE OF DEATH
Month Nov. Day 25. Year 1956 | | | | | | |
| 5. SEX
male | | 6. COLOR OR RACE
white | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
6/17/1912 | | 9. AGE (In years last birthday)
44 yrs. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
clerk | | 10b. KIND OF BUSINESS OR INDUSTRY
U.S. Gov. | | 11. BIRTHPLACE (State or foreign country)
Ala. | | 12. CITIZEN OF WHAT COUNTRY?
USA | | | | | |
| 13. FATHER'S NAME
John G. Sedberry | | | | | 14. MOTHER'S MAIDEN NAME
Aylmer Carr | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
yes | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Gertrude Sedberry (wife) Same # 2 | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Alcohol & barbiturate poisoning (accidental)
8809
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
(c) _____
DUE TO
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
--- | | | | | | | | | |
| 20c. TIME OF INJURY
Hour _____ o. m. _____ p. m. _____
Month, Day, Year _____ 19 _____ | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
--- | | 20f. (City or town)
--- | | (County) _____ (State) _____ | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>Frank J. Broschart</i>
EXAMINER'S NAME (Type) Frank J. Broschart | | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | | 22b. DATE THEREOF
11-28-56 | | 22c. NAME OF CEMETERY OR CREMATORY
Arlington Nat. Cem | | | 22d. LOCATION (City, town, or county) (State)
Arlington Virginia | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Robert A. Pumphrey | | | | | ADDRESS
Bethesda, Md. | | 24a. REC'D BY REGISTRAR
DATE 1-2-56 | | 24b. REGISTRAR'S SIGNATURE
<i>Bruce M. Thompson</i> | | |

NOV 28 1956

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11573

11591 CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|--|-----------------------------------|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>MONTGOMERY</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GLENMONT</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GLENMONT</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2721 MUNSON ST.</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Soo</u> Middle <u>FONG</u> Last <u>SEETOO</u> | | | | 4. DATE OF DEATH Month <u>Nov.</u> Day <u>9</u> Year <u>1956</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>Yellow</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>OCT. 1, 1882</u> | |
| 9. AGE (In years last birthday) <u>74</u> yrs. | | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | |
| 11. BIRTHPLACE (State or foreign country) <u>CHINA</u> | | | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| 13. FATHER'S NAME <u>MON LUNG SEETOO</u> | | | | 14. MOTHER'S MAIDEN NAME <u>HOMSE</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | | |
| 17. INFORMANT <u>CHUE HIK SEETOO</u> Address <u>2721 MUNSON ST GLENMONT MD.</u> | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pneumonia (Pulmonary)</u>
<u>493X</u> DUE TO
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <u>Pneumococcus (edema)</u>
DUE TO (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from <u>11/8/56</u> , 19____, to <u>11/9/56</u> , 19____, that I last saw the deceased alive on <u>11/9/56</u> , 19____, and that death occurred at <u>7:30 PM</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Patrick C Jameson</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>12020 Georgia Silver Spring Md.</u> | | | |
| PHYSICIAN'S NAME (Type) <u>PATRICK C JAMESON</u> | | | | DATE SIGNED <u>11/9/56</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF <u>11/13/56</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Leo West Park</u> | | 22d. LOCATION (City, town, or county) (State) <u>Hypothetical Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>J. W. Lees Son</u> ADDRESS <u>300-4th St. NE WASH DC</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>11/9/56</u> | | | |
| 24b. REGISTRAR'S SIGNATURE | | | | | | | |

NOV 14 1956

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

11595

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11574

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 218

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Gaithersburg</u> | | c. LENGTH OF STAY IN 1b
<u>life</u> | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Gaithersburg</u> | | d. STREET ADDRESS
<u>440 Gaither St.</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>440 Gaither St.</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Frank</u> Middle <u>Montgomery</u> Last <u>Selby</u> | | 4. DATE OF DEATH
Month <u>11</u> /Day <u>6</u> /Year <u>56</u> | |
| 5. SEX
<u>male</u> | 6. COLOR OR RACE
<u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH
<u>5/20/ 1891</u> |
| 9. AGE (In years last birthday)
<u>65</u> yrs. | | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> | IF UNDER 24 HRS.
Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>laborer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u> </u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>Howard Selby</u> | | 14. MOTHER'S MAIDEN NAME
<u>Martha E. Reed</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u> </u> | | 16. SOCIAL SECURITY NO.
<u> </u> | |
| 17. INFORMANT
<u>Fannie Muck (daughter)</u> | | Address
<u>Same as #2</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure</u>
<u>434.3</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic heart disease</u>
DUE TO (c) <u> </u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>4</u> hr.
<u>2</u> yrs. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u> </u> | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour <u> </u> a. m. <u> </u> p. m. <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u> </u> | | 20f. (City or town) (County) (State)
<u> </u> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>11-9-56</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY
<u>Forest Oak</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Gaithersburg</u> <u>Montg.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Frank J. Broschart</u> | | 24a. REC'D BY REGISTRAR
<u>Mr. G. - 56</u> | |
| 24b. REGISTRAR'S SIGNATURE
<u>Abraham L. Coode</u> | | DATE
<u>Nov. 9 - 56</u> | |

BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 11479 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12695

Reg. Dist. No.

773

| | | | | | | | |
|---|--------------------------------|--|--|---|--|---|---|
| 1. PLACE OF DEATH
o. COUNTY Montgomery
MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Montg. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Takoma Park | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Takoma Park | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
310 Tulip Ave. | | | | d. STREET ADDRESS
310 Tulip Ave. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First James Middle A Last Shorter | | | | 4. DATE OF DEATH
Month Nov. Day 29 Year 1956 | | | |
| 5. SEX
male | 6. COLOR OR RACE
ool | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | B. DATE OF BIRTH
7/26/1880 | | 9. AGE (In years last birthday)
76 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
laborer | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Unknown | | | | 14. MOTHER'S MAIDEN NAME
unknown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
310 Tulip Ave., Takoma Park, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary occlusion
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH
Found dead in chair at home | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE Frank J. Broschart | | | | DATE SIGNED 11/30/56 | | | |
| EXAMINER'S NAME (Type) Frank J. Broschart | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
12/9/56 | | 22c. NAME OF CEMETERY OR CREMATORY
Ash Memorial, | | 22d. LOCATION (City, town, or county) (State)
Sandy Spring, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Robert R. Swoode | | | | ADDRESS
Rockville, Md. | | 24a. REC'D BY REGISTRAR
DATE 12/20/56 | |
| | | | | | | 24b. REGISTRAR'S SIGNATURE
J. Wilson Bodd | |

MEDICAL CERTIFICATION

2

STATE OF MARYLAND
DEPARTMENT OF HEALTH—BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

DEC 12 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11596

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 11575

| | | | | | |
|---|---------------------------------------|--|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda
c. LENGTH OF STAY IN 1b | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Suburban Hospital 5625 Ogden Rd. | | | d. STREET ADDRESS
56 25 Ogden Road | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) ROY STEWART SIMMONS | | | 4. DATE OF DEATH Nov. 4, 1956 | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
7/11/14 | 9. AGE (In years last birthday)
42 yrs. | IF UNDER 1 YEAR
Months 3 Days 23 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Zone Mgr. | | 10b. KIND OF BUSINESS OR INDUSTRY
Ford Motor Co. | 11. BIRTHPLACE (State or foreign country)
Maryland | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Roy C. Simmon | | | 14. MOTHER'S MAIDEN NAME
Daisy Mumford | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
yes | | 16. SOCIAL SECURITY NO.
WW 11 225-10-1501 | 17. INFORMANT
Pearl Simmon-Item # 2 Wife | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Cerebral Hemorrhage & lacerations
976x DUE TO Compound fracture of skull
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____
DUE TO (c) _____ | | | | | INTERVAL BETWEEN ONSET AND DEATH
sudden |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Self inflicted shotgun wound (head practically decapitated) | | | |
| 20c. TIME OF INJURY
11:30 A.M. | Month, Day, Year
11/4/1956 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Home | 20f. (City or town)
Bethesda, Montg. Co., Md. | (County) _____ (State) _____ |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | |
| ACTUAL SIGNATURE Frank J. Broschart | | | DATE SIGNED 11/4/56 | | |
| EXAMINER'S NAME (Type) Frank J. Broschart, M.D. | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
11/7/1956 | 22c. NAME OF CEMETERY OR CREMATORY
Arlington National | 22d. LOCATION (City, town, or county) (State)
Arlington Virginia | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md. | | | 24a. REC'D BY REGISTRAR
DATE 1-9-56 | 24b. REGISTRAR'S SIGNATURE
Beattie M. Thompson | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH-BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | | | |
|------------------|--|-------------------|--|----------------|--|-----------------|--|-----------------------|--|
| NAME OF DECEASED | | AGE | | SEX | | RACE | | RELIGION | |
| DATE OF DEATH | | PLACE OF DEATH | | CAUSE OF DEATH | | MANNER OF DEATH | | SIGNATURE OF EXAMINER | |
| DATE OF BIRTH | | PLACE OF BIRTH | | EDUCATION | | OCCUPATION | | MARRIAGE | |
| DATE OF MARRIAGE | | PLACE OF MARRIAGE | | EDUCATION | | OCCUPATION | | MARRIAGE | |
| DATE OF DEATH | | PLACE OF DEATH | | CAUSE OF DEATH | | MANNER OF DEATH | | SIGNATURE OF EXAMINER | |
| DATE OF BIRTH | | PLACE OF BIRTH | | EDUCATION | | OCCUPATION | | MARRIAGE | |
| DATE OF MARRIAGE | | PLACE OF MARRIAGE | | EDUCATION | | OCCUPATION | | MARRIAGE | |

RECEIVED
NOV 13 1956
BUREAU V. 2

11597

CERTIFICATE OF DEATH

11576

Reg. Dist. No. 216

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>5422-Second St. N.W.</u> b. COUNTY <u>D.C.</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosmar Sanitarium Hospital</u> | | | | d. STREET ADDRESS <u>5721 Grosvenor Lane</u> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Eleanor Jane Skelly</u> | | | | 4. DATE OF DEATH Month <u>Nov.</u> Day <u>11</u> Year <u>1956</u> | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>30 April 1880</u> | |
| 9. AGE (In years last birthday) <u>76</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | |
| 11. BIRTHPLACE (State or foreign country) <u>WASHINGTON, D.C.</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | | | |
| 13. FATHER'S NAME <u>George Eckloff</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Nellie Sinn</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Paul J. Skelly</u> Address <u>5422-2nd St. NW Wash. D.C.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u>
442X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <u>260X</u> (b) <u>arteriosclerotic Cerebral-vascular-renal dis.</u>
DUE TO (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from <u>May 1, 1956</u> , to <u>Nov. 11, 1956</u> , that I last saw the deceased alive on <u>Nov. 10, 1956</u> , and that death occurred at <u>5:00 A.M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>R.S. Williams</u> | | | | ADDRESS (Street, city or town, state) <u>35 New York av. NW Wash. D.C.</u> DATE SIGNED <u>11/11/56</u> | | | |
| PHYSICIAN'S NAME (Type) <u>R.S. WILLIAMS</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>11-14-56</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>MT OLIVET</u> | | 22d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D.C.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis J. Collins</u> ADDRESS <u>3821-14th NW Wash. D.C.</u> | | | | 24a. REC'D BY REGISTRAR <u>1-13-56</u> | | 24b. REGISTRAR'S SIGNATURE <u>Bernie W. Thompson</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 15 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11598 CERTIFICATE OF DEATH

11577 EUNICE W. SLIGH

Reg. Dist. No. 213

| | | | | | |
|--|---|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u> | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>rural - Rockville</u> | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> | | |
| c. LENGTH OF STAY IN 1b <u>19 days</u> | | | d. STREET ADDRESS <u>544 Beall Avenue</u> | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Congressional Naval Sanatorium</u> | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) <u>Eunice W. Sligh</u> | | | 4. DATE OF DEATH <u>November 26 1956</u> | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Oct. 25, 1883</u> | | 9. AGE (In years lost birthday) <u>73</u> yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Gov.</u> | 11. BIRTHPLACE (State or foreign country) <u>West Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> |
| 13. FATHER'S NAME <u>William D. Withrow</u> | | | 14. MOTHER'S MAIDEN NAME <u>Mary D. Withrow</u> | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u></u> | 17. INFORMANT <u>Mrs Mary M. Balaguer</u> Address <u>1320 Jorgueil St NW DC</u> | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Congestive heart failure</u>
<u>450.0</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio sclerosis</u>
DUE TO (c) <u></u> | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
<u>20 years</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic cystitis</u> | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Hour a. <u>11</u> p. m. Month, Day, Year <u>19 12 19</u> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) |
| 21. I certify that I attended the deceased from <u>Nov 26</u> , 19 <u>56</u> , to <u>26 Nov</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>26 Nov</u> , 19 <u>56</u> , and that death occurred at <u>7:45 P.M.</u> , from the causes and on the date stated above. | | | | | |
| ACTUAL SIGNATURE <u>W. S. Murphy</u> | | ADDRESS (Street, city or town, state) <u>615 Washington Rockville, MD</u> DATE SIGNED <u>Nov 28</u> | | | |
| PHYSICIAN'S NAME (Type) <u>W. S. MURPHY</u> | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>Nov 28, 1956</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u> | 22d. LOCATION (City, town, or county) <u>Washington</u> | (State) <u>DC</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur S. Helms</u> | | ADDRESS <u>254 Carroll St NW DC</u> | | 24a. REC'D BY REGISTRAR <u>NOV 27 1956</u> | 24b. REGISTRAR'S SIGNATURE <u>Lawell Hargett</u> |

BUREAU V. S.

NOV 27 1956

RECEIVED

11480 CERTIFICATE OF DEATH

Reg. Dist. No. 223

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH
o. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47X-3 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u> | | | | d. STREET ADDRESS <u>822 Varnum St NW</u> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Charles Joseph Smith</u> | | | | 4. DATE OF DEATH Month <u>11</u> Day <u>6</u> Year <u>1956</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>8-19-92</u> | |
| 9. AGE (In years last birthday) <u>64</u> yrs. | | IF UNDER 1 YEAR Months <u>6</u> Days <u>19</u> | | IF UNDER 24 HRS. Hours <u>19</u> Min. <u>56</u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cab-driver</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>New Jersey</u> | | 11. BIRTHPLACE (State or foreign country) <u>USA</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | | | | | |
| 13. FATHER'S NAME <u>Charles J Smith</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Laura Bahanna</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | | | 16. SOCIAL SECURITY NO. <u>W.W.I</u> | | 17. INFORMANT Address <u>Hospital Records</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>
<u>420.1</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary</u>
DUE TO (c) _____ | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Previous Coronary Occlusion 4 yrs ago + Poss. b/y</u>
<u>3 wks ago</u> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. <u>19</u> p. m. | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) _____ (County) _____ (State) _____ | | | | | | | |
| 21. I certify that I attended the deceased from <u>Oct 1</u> , 19 <u>56</u> , to <u>Nov 6</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Nov 1</u> , 19 <u>56</u> , and that death occurred at <u>7:00 AM</u> , from the causes and on the date stated above. | | | | | | | |
| ADDRESS (Street, city or town, state) <u>Takoma Park 12 p.m. 11-6-56</u> | | | | DATE SIGNED <u>7:00 AM</u> | | | |
| ACTUAL SIGNATURE <u>James M. Whitlock</u> M.D. | | | | | | | |
| PHYSICIAN'S NAME (Type) <u>7600 Carroll Ave</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>Nov. 8, 1956</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Pr. Geo. Co. Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Dalters</u> ADDRESS <u>254 CARROLL ST</u> | | | | 24a. REC'D BY REGISTRAR <u>DATE 11/2/56</u> | | 24b. REGISTRAR'S SIGNATURE <u>J. M. L. Edell</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

[Faint, mostly illegible text from the reverse side of the document is visible through the paper. Discernible words include:]

NAME OF DECEASED: [illegible]
AGE: [illegible]
SEX: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
Cause of Death: [illegible]
Signature: [illegible]

BUREAU V. S.

NOV 2 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11599 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11579
Reg. Dist. No. 216

| | | | | | | | | |
|--|--------------------------------|---|--|--|--|--|---|--|
| 1. PLACE OF DEATH
o. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Bethesda</u> | | | c. LENGTH OF STAY IN 1b
<u>24 hrs</u> | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Germantown</u> | | | e. IS RESIDENCE ON A FARM?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Suburban Hosp.</u> | | | | d. STREET ADDRESS
<u>R F. D. #2</u> | | | | |
| 3. NAME OF DECEASED (Type or print) <u>Charles Roosevelt Smith</u>
First Middle Last | | | | 4. DATE OF DEATH <u>Nov. 22 1956</u>
Month Day Year | | | | |
| 5. SEX
<u>male</u> | 6. COLOR OR RACE
<u>col</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>Sept. 3, 1942</u> | | 9. AGE (In years last birthday)
<u>14</u> yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>student</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | |
| 13. FATHER'S NAME
<u>John Smith</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Dolly L. Shelton</u> | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | | 17. INFORMANT | | Address | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
<div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Fracture Skull & Sacration Brain</u>
 824x DUE TO
 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
 (b) <u>Confusion left Occiput</u>
 DUE TO
 (c) <u>Tractor Accident</u> </p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Confusion lower ext. Abdomen</u></p> </div> <div style="width: 15%; text-align: center;"> <p>INTERVAL BETWEEN ONSET AND DEATH
<u>24 hrs</u>
<u>24 hours</u>
<u>24 hrs</u> </p> </div> </div> | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u>Injured while driving farm tractor</u> | | | | | | |
| 20c. TIME OF INJURY
Hour <u>11/21/56</u> a. m. <u>4:05 P.M.</u> Month, Day, Year | | 20d. INJURY OCCURRED
While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u>Md R- 118</u> | | 20f. (City or town) (County) (State)
<u>Germantown Montg Md.</u> | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | | |
| ACTUAL SIGNATURE <u>Frank J. Broschart</u>
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u> | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED
<u>11/ 23/56</u> | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>11/25/56</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Lincoln Park,</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Rockville, Md.</u> | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Robert L. Menden</u> | | | | ADDRESS
<u>Be R. Md.</u> | | 24a. REC'D BY REGISTRAR
<u>DATE 1-27-57</u> | | |
| | | | | 24b. REGISTRAR'S SIGNATURE
<u>Bessie M. Thompson</u> | | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be furnished to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED
NOV 29 1956

9561 68 MON

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11600 CERTIFICATE OF DEATH

Reg. Dist. No.

11580
214

| | | | | | | | |
|---|----------------------------------|---|---|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Silver Spring, RFD | | | | c. LENGTH OF STAY IN 1b
2 weeks | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Fairland Nursing Home | | | | d. STREET ADDRESS
5509 Glenwood Road | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) FLORENCE M. SMITH | | | | 4. DATE OF DEATH
Month November Day 3 Year 19 56 | | | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Sept. 18, 1884 | | 9. AGE (In years last birthday)
72 yrs. | IF UNDER 1 YEAR
Months 1 Days 13 | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
Own Home | | 11. BIRTHPLACE (State or foreign country)
Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY?
US | |
| 13. FATHER'S NAME
Henry J. Smith | | | | 14. MOTHER'S MAIDEN NAME
Florence Wilson | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO.
(If yes, give war or dates of service) None | | 17. INFORMANT
Irma S. Albright-Item # 2 | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute congestive failure
420.0 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO
(c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH
28 days
10 years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
PARALYSIS AGITANS | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Hour o. p. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Oct 5 , 19 56 to Nov 3 , 19 56 that I last saw the deceased alive on Oct 19 , 19 56 , and that death occurred at 11:00 P.M. , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) WASHINGTON CLINIC DATE SIGNED 11/4/56 | | | | | | | |
| ACTUAL SIGNATURE Michael M. Healy | | M.D. WASHINGTON CLINIC | | | | | |
| PHYSICIAN'S NAME (Type) MICHAEL M HEALY | | WASHINGTON 15 DC | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
11-6-1956 | | 22c. NAME OF CEMETERY OR CREMATORY
Cedar Hill | | 22d. LOCATION (City, town, or county) (State)
Prince Georges Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Robert A. Pumphrey | | | | ADDRESS
Bethesda Md | | 24a. REC'D BY REGISTRAR
DATE 11/6/56 | |
| | | | | 24b. REGISTRAR'S SIGNATURE
Frances Potter | | | |

CERTIFICATE OF DEATH

FILE NO.

DATE OF DEATH

PLACE OF DEATH

DECEASED

DATE OF BIRTH

DATE OF DEATH

SEX

AGE

CAUSE OF DEATH

SEX

PLACE OF BIRTH

PLACE OF DEATH

CAUSE OF DEATH

DECEASED

DECEASED

DECEASED

DECEASED

BUREAU V. S.

NOV 8 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11601 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11581

Reg. Dist. No. 216

| | | | | | | | | | |
|--|--|---|--|--|--|---|---|---|--|
| 1. PLACE OF DEATH
o. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission)
o. STATE Maryland b. COUNTY Montgomery | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Chevy Chase | | | c. LENGTH OF STAY IN 1b
22 years | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Chevy Chase | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
14 W. Irving Street | | | | d. STREET ADDRESS
14 W. Irving Street | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First Isis Middle Ingelby Last SNYDER | | | | 4. DATE OF DEATH
Month November Day 24 Year 19 56 | | | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Jan. 22, 1865 | | | |
| 9. AGE (In years last birthday)
91 yrs. | | IF UNDER 1 YEAR
Months 10 Days 2 | | IF UNDER 24 HRS.
Hours 2 Min. | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | 10b. KIND OF BUSINESS OR INDUSTRY
- - - - - | | 11. BIRTHPLACE (State or foreign country)
West Virginia | | 12. CITIZEN OF WHAT COUNTRY?
USA | | |
| 13. FATHER'S NAME
Harvey Woodford | | | | 14. MOTHER'S MAIDEN NAME
Ingelby Thompson | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT
Address
Esther A. Snyder-Same Item #2 | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Cardiac failure
782.4 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
18 hours | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20c. TIME OF INJURY
Hour _____ a. m. _____ p. m. _____
Month, Day, Year 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) _____ (County) _____ (State) _____ | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | | | |
| ACTUAL SIGNATURE <i>Frank J. Broschart</i>
EXAMINER'S NAME (Type) Frank J. Broschart, | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | DATE SIGNED
11/24/1956 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Cremation | | 22b. DATE THEREOF
11/24/1956 | | 22c. NAME OF CEMETERY OR CREMATORY
Cedar Hill | | 22d. LOCATION (City, town, or county) _____ (State) _____
Prince Georges Maryland | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Robert A. Pumphrey-7557 Wis. Ave. Beth. Md. | | | | 24a. REC'D BY REGISTRAR
DATE NOV 27 1956 | | 24b. REGISTRAR'S SIGNATURE
<i>Barrie Thompson</i> | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED
NOV 27 1956
BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11582

11602 CERTIFICATE OF DEATH

Reg. Dist. No. 116

| | | | | | | | |
|---|------------------------|--|--------------------------------|---|-----------------|---|------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY MONTGOMERY | | MARYLAND | | STATE MARYLAND | | COUNTY MONTGOMERY | |
| CITY (If outside corporate limits, write RURAL and give nearest town) BETHESDA | | LENGTH OF STAY (in this place) 2 yrs. | | CITY (If outside corporate limits, write RURAL and give nearest town) BETHESDA | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS 7907 KENTUCKY AVENUE | | | | STREET ADDRESS (If rural give location) 7907 KENTUCKY AVENUE | | | |
| 3. NAME OF DECEASED (Type or Print) (First) MARY (Middle) LYSTON (Last) SPRECKELMYER | | | | 4. DATE OF DEATH (Month) Nov (Day) 12 (Year) 1956 | | | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWED | 8. DATE OF BIRTH OCT. 28, 1867 | 9. AGE last birthday 89 yrs. | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| | | | | Months | | Days | Hours |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER - retired | | | | 10b. KIND OF BUSINESS OR INDUSTRY OWN HOME | | 11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME EDWARD LYSTON | | | | 14. MOTHER'S MAIDEN NAME ELIZABETH BROPHY | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NO | | 16. SOCIAL SECURITY NO. NONE | | 17. INFORMANT & ADDRESS Mr. John I. Spreckelmyer, 3715 Chevy Chase Lake Drive, Chevy Chase, Md. | | | |
| 18. MEDICAL CERTIFICATION | | | | INTERVAL BETWEEN ONSET AND DEATH 48 hrs | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| 422.1 IMMEDIATE CAUSE (A) Acute Coronary Cardiac failure | | | | | | | |
| ANTECEDENT CAUSE(S) DUE TO (B) Gen. arteriosclerosis, myocarditis | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Senility & Malnutrition | | | | | | | |
| 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 2D. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | | 21a. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from Sept 4, 1956, to Nov 12, 1956, that I last saw the deceased alive on Nov 9, 1956, and that death occurred at 6:15 P.M. from the causes and on the date stated above. | | | | | | | |
| SIGNATURE Dr. J. J. Courtney | | | | ADDRESS (Street, city, town, state) 5601-400 N. Park Rd Silver Spring, Md. | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | DATE THEREOF 11/14/56 | | NAME OF CEMETERY OR CREMATORY ST. MARY'S CATH. CEMETERY | | LOCATION (City, town, or county) LAUREL, MARYLAND (State) | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE Beanie M. Thompson | | 25. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey | | ADDRESS Silver Spring, Md. | |
| DATE 11-13-56 | | | | | | | |

CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF NEXT OF KIN

15. SIGNATURE OF BURIAL OFFICIAL

16. SIGNATURE OF CHURCH OFFICIAL

17. SIGNATURE OF FUNERAL HOME

18. SIGNATURE OF CEMETERY

19. SIGNATURE OF INTERVIEWER

20. SIGNATURE OF OFFICIAL

21. SIGNATURE OF CLERK

22. SIGNATURE OF ASSISTANT

23. SIGNATURE OF DEPUTY

24. SIGNATURE OF SECRETARY

25. SIGNATURE OF CHIEF

26. SIGNATURE OF DIRECTOR

27. SIGNATURE OF COMMISSIONER

28. SIGNATURE OF ATTORNEY

29. SIGNATURE OF JUDGE

30. SIGNATURE OF CLERK

31. SIGNATURE OF ASSISTANT

32. SIGNATURE OF DEPUTY

33. SIGNATURE OF SECRETARY

34. SIGNATURE OF CHIEF

35. SIGNATURE OF DIRECTOR

BUREAU V. 3

OV 15 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11603 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11583

Reg. Dist. No. 214

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Silver Spring | | c. LENGTH OF STAY IN 1b
D. O. A. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Washington, D. C. | | d. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
8000 Georgia Ave., in his car | | | | d. STREET ADDRESS
1624 Upshur St., N. W. | | | |
| 3. NAME OF DECEASED (Type or print) CHARLES STANLEY STEVENSON
<div style="text-align: center; font-size: small;">First Middle Last</div> | | | | 4. DATE OF DEATH
November 19 19 56
<div style="text-align: center; font-size: small;">Month Day Year</div> | | | |
| 5. SEX
male | | 6. COLOR OR RACE
white | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Nov. 15, 1888 | |
| 9. AGE (In years last birthday)
68 yrs. | | IF UNDER 1 YEAR
Months Days | | IF UNDER 24 HRS.
Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Attorney-U.S. Veterans' Admr., U.S. Gov't., ret. | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Topeka, Kansas | | 11. BIRTHPLACE (State or foreign country)
U. S. A. | |
| 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | | | | | | |
| 13. FATHER'S NAME
James H. Stevenson | | | | 14. MOTHER'S MAIDEN NAME
Emma A. Shepard | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
Yes | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT Address
Mrs. Marian Q. Stevenson, 1624 Upshur St., N. W. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
<div style="border: 1px solid black; padding: 5px;"> PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) Coronary occlusion
 DUE TO
 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____
 DUE TO (c) _____ </div> | | | | | | INTERVAL BETWEEN ONSET AND DEATH
sudden | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
19 | | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE Frank J. Broschart | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED | |
| EXAMINER'S NAME (Type) Frank J. Broschart, M. D. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
burial | | 22b. DATE THEREOF
11/23/56 | | 22c. NAME OF CEMETERY OR CREMATORY
Arlington Nat. Cemetery | | 22d. LOCATION (City, town, or county) (State)
Arlington, Virginia | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
The S.H. Hines Co., 2901 14th St. N.W., | | | | ADDRESS
Wash, D.C. | | 24a. REC'D BY REGISTRAR
DATE 11/21/56 | |
| 24b. REGISTRAR'S SIGNATURE
James Potter | | | | 24c. REGISTRAR'S SIGNATURE | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the funeral director, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
NOV 26 1956
BUREAU Y. L.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11584

11604 CERTIFICATE OF DEATH

Reg. Dist. No.

214

| | | | |
|--|----------------------------------|--|------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Md.</u> b. COUNTY <u>Mont.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Silver Spring</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Silver Spring</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS
<u>901 Robbin Rd.</u> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
<u>Mary E. Stewart</u> | | 4. DATE OF DEATH
Month Day Year
<u>Nov. 8, 1956</u> 19 | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
<u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Aug. 11</u> |
| 9. AGE (In years last birthday)
<u>82</u> yrs. | | IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Home</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>Wash. D. C.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U. S. A.</u> | |
| 13. FATHER'S NAME
<u>Frank E. Nussbaum</u> | | 14. MOTHER'S MAIDEN NAME
<u>Mary Ellen Tyser</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
<u>Iva M. Mansfield</u> | | Address
<u>2800 Quebec St. N. W.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Myocardial infarction</u>
<u>420.1</u> DUE TO
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) <u>Congestive heart failure</u>
(c) <u>Arteriosclerotic cardiovascular disease</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>5 minutes</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>June</u> , 195 <u>6</u> , to <u>Nov 8</u> , 195 <u>6</u> , that I last saw the deceased alive on <u>Nov 11</u> , 195 <u>6</u> , and that death occurred at <u>11:20</u> P. M., from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Raymond Bradshaw</u> M.D. | | DATE SIGNED <u>10331 Old Bladensburg Rd</u> | |
| PHYSICIAN'S NAME (Type) <u>Raymond Bradshaw</u> | | <u>Silver Spring, Md.</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>Nov. 13, 1956</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY
<u>Glenwood Cemetery</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Washington, D. C.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Deal Funeral Home</u> | | ADDRESS
<u>4812 Ga. Ave. N.W.</u> | |
| 24a. REC'D BY REGISTRAR
<u>DATE 11/13/56</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Francis Catter</u> | |

CERTIFICATE OF DEATH

STATE OF MARYLAND

COUNTY OF BALTIMORE

WITNESSETH that on this 11th day of November 1956

at the City of Baltimore

in the County of Baltimore

that the following named person

has died

at the residence of the decedent

at the City of Baltimore

in the County of Baltimore

that the decedent was

born on the 11th day of November 1956

at the City of Baltimore

in the County of Baltimore

that the decedent was

born on the 11th day of November 1956

at the City of Baltimore

in the County of Baltimore

that the decedent was

born on the 11th day of November 1956

at the City of Baltimore

in the County of Baltimore

that the decedent was

born on the 11th day of November 1956

at the City of Baltimore

in the County of Baltimore

that the decedent was

born on the 11th day of November 1956

at the City of Baltimore

in the County of Baltimore

that the decedent was

born on the 11th day of November 1956

at the City of Baltimore

in the County of Baltimore

that the decedent was

born on the 11th day of November 1956

at the City of Baltimore

in the County of Baltimore

BUREAU V. 3

NOV 16 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11437 CERTIFICATE OF DEATH

11585

Reg. Dist. No. 213

| | | | | | | | |
|---|---|---|--|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rockville | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rockville | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
243 E. Montgomery Ave. | | | | d. STREET ADDRESS
243 E. Montgomery Ave. | | | |
| 3. NAME OF DECEASED (Type or print)
First DORA Middle EMILY Last STREAM | | | | 4. DATE OF DEATH
Month Nov. Year 1956 Day 19 | | | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Sept. 30, 1895 | 9. AGE (In years last birthday)
61 yrs. | IF UNDER 1 YEAR
Months 1 Days 19 | IF UNDER 24 HRS.
Hours 19 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
Own Home | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Amos Whipp | | | | 14. MOTHER'S MAIDEN NAME
Alice Webster | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT
Wm. R. Stream - Item # 2 | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS
443X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSIVE ARTERIOSCLEROTIC
DUE TO (c) HEART DISEASE | | | | | | INTERVAL BETWEEN ONSET AND DEATH
TWO DAYS
TEN YEARS | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m. 19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) | | |
| 21. I certify that I attended the deceased from SEPT. 5, 1955 , to NOV. 19, 1956 , that I lost saw the deceased alive on 12 NOV. 1956 , and that death occurred at 6:30 A. M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE
Gordon S. Rosenberger | | M.D.
Rockville, Md. | | ADDRESS (Street, city or town, state)
310 W. Montg. Ave. Rockville, Md. | | DATE SIGNED
19 Nov 1956 | |
| PHYSICIAN'S NAME (Type)
Gordon S. Rosenberger | | ADDRESS
Bethesda, Md. | | 24a. REC'D BY REGISTRAR
DATE 11/20/56 | | 24b. REGISTRAR'S SIGNATURE
Laurel Kragtorp | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
11-21-56 | 22c. NAME OF CEMETERY OR CREMATORY
Forest Oak Cem | | 22d. LOCATION (City, town, or county) (State)
Gaithersburg Maryland | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Robert A. Pumphrey | | | | | | | |

CERTIFICATE OF DEATH

| | | | | | | | | | |
|---|--|---|--|--|--|------------------------------------|--|---|--|
| NAME OF DECEASED
JOHN J. HARRIS | | AGE
45 | | SEX
Male | | RACE
White | | DATE OF BIRTH
Nov. 10, 1910 | |
| PLACE OF BIRTH
Baltimore, Md. | | OCCUPATION
Carpenter | | EDUCATION
High School | | MARRIAGE
Married | | DATE OF MARRIAGE
Jan. 15, 1935 | |
| RESIDENCE
1234 North Howard Ave. | | DATE OF DEATH
Nov. 15, 1956 | | TIME OF DEATH
10:30 AM | | PLACE OF DEATH
Home | | CAUSE OF DEATH
Heart Disease | |
| IMMEDIATE CAUSE OF DEATH
Myocardial Infarction | | MEDICAL HISTORY
Hypertension, Diabetes | | TREATMENT
Medication | | POST-MORTEM
No | | SIGNATURE OF PHYSICIAN
J. H. Smith, M.D. | |
| SIGNATURE OF DECEASED
(None) | | SIGNATURE OF NEXT OF KIN
Mary Harris | | SIGNATURE OF WITNESSES
John Doe, Jane Doe | | SIGNATURE OF REGISTRAR
John Doe | | SIGNATURE OF CLERK
John Doe | |

BUREAU V. E.

NOV 21 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
11605 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11586
214

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <i>Montgomery</i> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission)
a. STATE <i>MD</i> b. COUNTY <i>Montg</i> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>Kensington</i> | | c. LENGTH OF STAY IN 1b
<i>4 mo</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>Kensington</i> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<i>10916 Drum Ave</i> | | | | d. STREET ADDRESS
<i>10916 Drum Ave</i> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <i>Henry</i> Middle <i>Tanke</i> Last <i></i> | | | | 4. DATE OF DEATH
Month <i>Nov</i> Day <i>19</i> Year <i>1956</i> | | | |
| 5. SEX
<i>male</i> | | 6. COLOR OR RACE
<i>white</i> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<i>1-17-1863</i> | |
| 9. AGE (In years last birthday)
<i>93</i> yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS.
Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Lab.</i> | | 10b. KIND OF BUSINESS OR INDUSTRY
<i>meat market</i> | | 11. BIRTHPLACE (State or foreign country)
<i>Germany</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | |
| 13. FATHER'S NAME
<i>Unknown</i> | | | | 14. MOTHER'S MAIDEN NAME
<i>Unknown</i> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<i></i> | | 16. SOCIAL SECURITY NO.
<i></i> | | 17. INFORMANT
<i>Mary McDonald - Same as Item 2</i> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Pulmonary edema</i>
421.4 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <i>Chronic cardiac valvular disease</i>
DUE TO
(c) <i></i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<i>hypertension - several years</i> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<i></i> | | | | | |
| 20c. TIME OF INJURY
Hour o. m. p. m. <i>19</i> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<i></i> | | 20f. (City or town) (County) (State)
<i></i> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| 22a. BURIAL, CREMATION, or other disposition (Specify)
<i></i> | | | | 22b. DATE THEREOF
<i>11-23-56</i> | | 22c. NAME OF CEMETERY OR CREMATORY
<i>WEB HANKEN Cemetery</i> | |
| 22d. LOCATION (City, town, or county) (State)
<i>NORTH BERGEN - New Jersey</i> | | | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<i>Timothy Hanlon - 3831-GR. Ave N.W.</i> | | | | 24a. REC'D BY REGISTRAR
<i>NOV 26 1956</i> | | 24b. REGISTRAR'S SIGNATURE
<i>Frances Potter</i> | |

NOV 26 1956

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11587

11606 CERTIFICATE OF DEATH

Reg. Dist. No. 216

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE D. C.
b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda 14, Maryland | | c. LENGTH OF STAY IN 1b
3 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION
The Clinical Center, Bethesda 14, Md. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Washington
47x-3 | |
| d. STREET ADDRESS
7650 Livingston Road, S. E. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First Martha Middle Teuber Last Teuber | | 4. DATE OF DEATH
Month November Day 18 Year 19 56 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
September 6, 1893 |
| 9. AGE (In years lost birthday)
63 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country)
Germany | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
Joseph Tilch | | 14. MOTHER'S MAIDEN NAME
Anna Stein | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
None | |
| 17. INFORMANT
The Medical Record | | Address
The Clinical Center, Bethesda 14, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Peripheral Vascular Collapse
527.2
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Chronic pulmonary suppurative disease
DUE TO
(c)
INTERVAL BETWEEN ONSET AND DEATH
3 1/2 hrs
5 yrs | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. 11 p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from November 15, 19 56 , to November 18, 19 56 , that I last saw the deceased alive on November 18, 19 56 , and that death occurred at 2:30 A.M. , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Donald Bruce Louria | | ADDRESS (Street, city or town, state) The Clinical Center
DATE SIGNED 11-18-56 | |
| PHYSICIAN'S NAME (Type) Donald Bruce Louria, M. D. | | National Institutes of Health
Bethesda 14, Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
Nov. 20-56 | |
| 22c. NAME OF CEMETERY OR CREMATORY
St. Johns | | 22d. LOCATION (City, town, or county) (State)
Broadcreek Pk. Geo. Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Simmons Bros. | | ADDRESS
1661-2000 N. H. Ave. SE
Wash. 20 150 | |
| 24a. REC'D BY REGISTRAR
NOV 20 1956 | | 24b. REGISTRAR'S SIGNATURE
Bessie Thompson | |

RECEIVED

BUREAU 2

BUREAU 2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11588

11607 CERTIFICATE OF DEATH

Reg. Dist. No. 215

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> <u>MARYLAND</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission)
a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Bethesda (Rural)</u> | | c. LENGTH OF STAY IN 1b
<u>1 month</u> | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Washington</u> | | d. STREET ADDRESS
<u>2700 "Q" Street, North West</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>U.S. Naval Hospital, Bethesda, Md.</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) <u>Virginia</u> <u>Leita</u> <u>THOMPSON</u> | | 4. DATE OF DEATH
Month <u>November</u> Day <u>6</u> Year <u>19 56</u> | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>Cauc.</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
<u>WIDOWED</u> <input checked="" type="checkbox"/> <u>DIVORCED</u> <input type="checkbox"/> | 8. DATE OF BIRTH
<u>28 December 1892</u> |
| 9. AGE (In years, last birthday)
<u>63</u> yrs. | | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u> </u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>New York</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.</u> | |
| 13. FATHER'S NAME
<u>Emile MONTGOMERY</u> | | 14. MOTHER'S MAIDEN NAME
<u>Ella HORSEY</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
<u>577 46 6176</u> | |
| 17. INFORMANT <u>Daughter</u> | | Address
<u>Elizabeth BROWN 3530 "T" ST., NW, Washington, D.C.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pulmonary Emboli, Multiple</u>
<u>465X</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>4 weeks</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u> </u> | |
| 20c. TIME OF INJURY Month, Day, Year
Hour <u> </u> o. m. <u>19</u> p. m. <u> </u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u> </u> | | 20f. (City or town) (County) (State)
<u> </u> | |
| 21. I certify that I attended the deceased from <u>7 Oct.</u> , 19 <u>56</u> , to <u>6 Nov.</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>6 Nov.</u> , 19 <u>56</u> , and that death occurred at <u>1:40A. M.</u> , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) <u>U.S. Naval Hospital, Bethesda, Md.</u> DATE SIGNED <u>11-6-56</u> | | | |
| ACTUAL SIGNATURE <u>A. J. Cappelletti, M.D.</u> | | U.S. Naval Hospital, Bethesda, Md. | |
| PHYSICIAN'S NAME (Type) <u>A. J. CAPPELLETTI, LCDR, MC, USN</u> | | U.S. Naval Hospital, Bethesda, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>11-9-56</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY
<u>Arlington Nat'l Cemetery</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Arlington, Va.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Gawler's & Sons</u> | | ADDRESS
<u>1756 Penn. Ave., N.W. Wash. D.C.</u> | |
| 24a. REC'D BY REGISTRAR
<u> </u> | | 24b. REGISTRAR'S SIGNATURE
<u> </u> | |

RECEIVED
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BUREAU V. S.

1956 O NOV

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11608

CERTIFICATE OF DEATH

Reg. Dist. 11589

| | | | | | | | |
|--|----------------------------------|---|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Virginia b. COUNTY Fairfax | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda 14, Maryland | | | | c. LENGTH OF STAY IN 1b
4 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
The Clinical Center, Bethesda 14, Md. | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First William Middle Donald Last Thompson | | | | 4. DATE OF DEATH
Month November Day 16 Year 1956 | | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
April 1, 1922 | 9. AGE (In years last birthday)
34 yrs. | IF UNDER 1 YEAR
Months 34 Days 0 Hours 0 Min. 0 | IF UNDER 24 HRS.
Months 0 Days 0 Hours 0 Min. 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Newspaperman | | 10b. KIND OF BUSINESS OR INDUSTRY
Newspaper | | 11. BIRTHPLACE (State or foreign country)
Virginia | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
Bertram Thompson | | | | 14. MOTHER'S MAIDEN NAME
Mamie Crosen | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
578-12-1803 | | 17. INFORMANT The Medical Record Address
The Clinical Center, Bethesda 14, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Arrest
193X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Medullary Compression
(c) This blastoma left temporal lobe | | | | | | INTERVAL BETWEEN ONSET AND DEATH
12 hrs.
2 mos.? | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. 11 p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from November 12, 1956 , to November 16, 1956 , that I last saw the deceased alive on November 16, 1956 , and that death occurred at 4:25 AM , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE
John F. Lane, | | M.D. The Clinical Center | | ADDRESS (Street, city or town, state)
National Institutes of Health | | DATE SIGNED
11/16/56 | |
| PHYSICIAN'S NAME (Type)
John F. Lane, M. D. | | Bethesda 14, Maryland | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
11/19/56 | | 22c. NAME OF CEMETERY OR CREMATORY
National Memorial Park | | 22d. LOCATION (City, town, or county) (State)
Hall Church Va | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Charles Funeral Home | | ADDRESS
Fairfax Va | | 24a. REC'D BY REGISTRAR
DATE 11/19/56 | | 24b. REGISTRAR'S SIGNATURE
Frances Catter | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11609

CERTIFICATE OF DEATH

11590

Reg. Dist. No. 216

| | | | | | | | |
|--|----------------------------------|---|--|---|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Rural Bethesda</u> | | | c. LENGTH OF STAY IN 1b
<u>10 years</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Rural, Bethesda</u> | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | d. STREET ADDRESS
<u>9232 Farnsworth Drive</u> | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)
First <u>Catherine</u> Middle <u>Throckmorton</u> Last | | | | 4. DATE OF DEATH
Month <u>Nov.</u> Day <u>14th.</u> Year <u>1956</u> | | | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>9/26/1863</u> | | 9. AGE (In years last birthday)
<u>93</u> yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>Baltimore, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>John Bonnett</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>? Creamer</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | | 17. INFORMANT Address
<u>Horace U. Throckmorton 9232 Farnsworth Dr.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute pulmonary embolism</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>902.0</u>
(b) <u>post-operative embolism following</u>
DUE TO
(c) <u>Surgical pinning of fracture r-t. hip</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>10 min</u>
<u>10 days</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>1) Fracture of hip 2) Diabetes Mellitus 3) Senility</u> | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u>Pt. fell getting out of bed at home Oct 30 1956</u> | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. <u>10</u> 30 1956 p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u>Home</u> | | 20f. (City or town) (County) (State)
<u>Bethesda Montgomery Md.</u> | |
| 21. I certify that I attended the deceased from <u>Nov 13</u> , 19 <u>56</u> , to <u>Nov 14</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Nov 13</u> , 19 <u>56</u> , and that death occurred at <u>6:00 P.M.</u> , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) <u>3921 Ingomar St. N.W. Wash 15 D.C.</u> DATE SIGNED <u>11-14-56</u> | | | | | | | |
| ACTUAL SIGNATURE <u>Stewart Clapp</u> | | | | M.D. <u>3921 Ingomar St. N.W. Wash 15 D.C.</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Stewart Clapp</u> | | | | ADDRESS <u>Wash 15 D.C.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>11/17/56</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Rock Creek Cemetery</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Washington, D. C. Suitland, Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Joseph F. Birch's Son</u> | | | | ADDRESS
<u>3034 M ST. N.W., WASH, D.C.</u> | | 24a. REC'D BY REGISTRAR
<u>DATE 11-17-56</u> | |
| 24b. REGISTRAR'S SIGNATURE
<u>Beattie M. Thompson</u> | | | | 24c. REGISTRAR'S SIGNATURE | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | |
|-----------------------|--|------------------------|--|------------------------|--|
| NAME OF DECEASED | | DATE OF BIRTH | | DATE OF DEATH | |
| JAMES H. HARRIS | | JANUARY 1, 1900 | | JANUARY 1, 1960 | |
| MARRIAGE | | PLACE OF BIRTH | | PLACE OF DEATH | |
| MARRIED | | BALTIMORE, MD | | BALTIMORE, MD | |
| EDUCATION | | OCCUPATION | | CAUSE OF DEATH | |
| HIGH SCHOOL | | LABORER | | HEART DISEASE | |
| RELIGION | | MANNER OF DEATH | | PLACE OF INTERMENT | |
| METHODIST | | NATURAL | | CATHOLIC CHURCH | |
| SIGNATURE OF DECEASED | | SIGNATURE OF WITNESSES | | SIGNATURE OF PHYSICIAN | |
| | | | | | |
| DATE OF SIGNATURE | | DATE OF SIGNATURE | | DATE OF SIGNATURE | |
| | | | | | |
| NAME OF PHYSICIAN | | NAME OF CLERGYPERSON | | NAME OF REGISTRAR | |
| DR. J. H. HARRIS | | REVEREND J. H. HARRIS | | JOHN H. HARRIS | |
| ADDRESS | | ADDRESS | | ADDRESS | |
| BALTIMORE, MD | | BALTIMORE, MD | | BALTIMORE, MD | |
| CITY | | COUNTY | | STATE | |
| BALTIMORE | | BALTIMORE | | MARYLAND | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11610

CERTIFICATE OF DEATH

Reg. Dist. No.

11591
216

| | | | |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Connecticut b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda 14, Md. | | c. LENGTH OF STAY IN 1b
89 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
The Clinical Center, Bethesda 14, Md. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Quaker Hill | |
| d. STREET ADDRESS
Old Norwich Road | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Michael Middle Andrew Last Trautman | | 4. DATE OF DEATH
Month November Day 2 Year 19 56 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
October 7, 1935 |
| 9. AGE (In years last birthday) 21 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Student | | 10b. KIND OF BUSINESS OR INDUSTRY
College | |
| 11. BIRTHPLACE (State or foreign country)
Nebraska | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
Harry G. Trautman | | 14. MOTHER'S MAIDEN NAME
Mary E. Hogan | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
Unknown | |
| 17. INFORMANT
The Medical Record | | Address
The Clinical Center, Bethesda 14, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Ewing's Sarcoma
196X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. p. 19 p. m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from August 5 , 19 56 , to November 2 , 19 56 , that I last saw the deceased alive on November 2 , 19 56 , and that death occurred at 11:15 A. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED
ACTUAL SIGNATURE Arthur J. Garceau M.D. The Clinical Center
National Institutes of Health
Bethesda 14, Maryland
PHYSICIAN'S NAME (Type) Arthur J. Garceau, M. D. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
11-6-56 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Arlington National | | 22d. LOCATION (City, town, or county) (State)
Arlington, Virginia | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Robert A. Pumphrey-Bethesda, Md. | | 24a. REC'D BY REGISTRAR
DATE 11-5/56 | |
| 24b. REGISTRAR'S SIGNATURE
Beanie M. Thompson | | | |

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

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Robert A. Pumphrey-Botkins, M.D.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose a certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File—pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
11438 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11592
Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>Conn</u> b. COUNTY <u>New London</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Rockville</u> | | c. LENGTH OF STAY IN 1b
<u>2 days</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Mystic</u> | | 45 x -3 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>N. First St.</u> | | | | d. STREET ADDRESS
<u>Pedest-Sigee Rd.</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Margaret</u> Middle <u>Louise</u> Last <u>Truss</u> | | | | 4. DATE OF DEATH
Month <u>Nov</u> Day <u>9</u> Year <u>1956</u> | | | |
| 5. SEX
<u>Female</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>9-25-1888</u> | |
| 9. AGE (In years last birthday)
<u>68</u> yrs. | | IF UNDER 1 YEAR
Months <u>1</u> Days <u>14</u> | | IF UNDER 24 HRS.
Hours <u></u> Min. <u></u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Home</u> | | 11. BIRTHPLACE (State or foreign country)
<u>N.Y.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.C.</u> | |
| 13. FATHER'S NAME
<u>Joseph Hyatt</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Margaret Dussentbury</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>No</u> | | 17. INFORMANT
Address <u>Ethel Savage (daughter) Same as #1</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary occlusion</u>
<u>420.1</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u>
DUE TO (c) <u></u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hyperextension 13 yrs</u> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | | | 22b. DATE THEREOF
<u>11-14-56</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Arlington National</u> | |
| 22d. LOCATION (City, town, or county)
<u>Arlington</u> | | | | 22e. (State)
<u>Virginia</u> | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Robert A. Pumphrey</u> | | | | ADDRESS
<u>Bethesda Md</u> | | 24a. REC'D BY REGISTRAR
DATE <u>11/13/56</u> | |
| 24b. REGISTRAR'S SIGNATURE
<u>Lawell Kragtorp</u> | | | | | | | |

DATE SIGNED

11-9-56

REC

RECEIVED

BUREAU V. S.

11481

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

223

| | | | | | | | |
|---|----------------------------------|---|--|--|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>MD</u> b. COUNTY <u>P. G.</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Takoma Park</u> | | c. LENGTH OF STAY IN 1b
<u>D.O.A.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Hillside</u> | | 168-2 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Washington Sanitarium & Hospital</u> | | | | d. STREET ADDRESS
<u>1213 55th Ave</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Morris</u> Middle <u>Edward</u> Last <u>Tyson</u> | | | | 4. DATE OF DEATH
Month <u>Nov</u> Day <u>20</u> Year <u>1956</u> | | | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>11-29-16</u> | | 9. AGE (In years last birthday)
<u>39</u> yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Construction</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>—</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Bernard Tyson</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Mollie Hall</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>NO</u> | | 16. SOCIAL SECURITY NO.
<u>Unknown</u> | | 17. INFORMANT
<u>Hof. Record</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary occlusion</u>
<u>420.1</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u>
DUE TO (c) <u>—</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>sudden</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Hour <u>—</u> a. m. <u>19</u> p. m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE <u>Frank J. Bruschant</u> | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED | |
| EXAMINER'S NAME (Type) <u>FRANK J. BRUSCHANT</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | <u>11-20-56</u> | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | | |
| 22a. BURIAL, CREMATION, or REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>Nov 24/56</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>West Park Cemetery</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Suitland, Prince Georges Co. MD</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>W.W. Chambers of Washington DC</u> | | | | ADDRESS | | 24a. REC'D BY REGISTRAR
DATE <u>11/23/56</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE
<u>J. Wilson Doh</u> | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1956 83 AOK

11611 CERTIFICATE OF DEATH

Reg. Dist. No. 218

| | | | | | | | |
|--|---|---|---------------------------------------|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Germantown-Rural</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Germantown</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | d. STREET ADDRESS | | | |
| e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>SAMUEL</u> Middle <u>L</u> Last <u>UMBERGER</u> | | | | 4. DATE OF DEATH
Month <u>Nov.</u> Day <u>16</u> Year <u>19 56</u> | | | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>12-6-1886</u> | 9. AGE (In years last birthday)
<u>69</u> yrs. | IF UNDER 1 YEAR
Months <u>11</u> Days <u>10</u> | IF UNDER 24 HRS.
Hours <u>10</u> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Painter</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>House Painter</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>Rufus UMBERGER</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Liza Jane --</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>Unknown</u> | | 17. INFORMANT
<u>Son - Paul UMBERGER, Germantown, Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Adenocarcinoma of Prostate</u>
DUE TO <u>177x</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) _____
(c) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>9 years.</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. _____ p. m. _____ 19 _____ | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) | | |
| 21. I certify that I attended the deceased from <u>Aug. 19, 1956</u> to <u>Nov. 16, 1956</u> , that I lost saw the deceased alive on <u>Nov. 15, 1956</u> , and that death occurred at <u>3:10 P.M.</u> from the causes and on the date stated above. | | | | | | | DATE SIGNED |
| ACTUAL SIGNATURE
<u>Jack Schumacher</u> | | M.D. <u>Gaithersburg, Md.</u> | | ADDRESS (Street, city or town, state) | | | DATE SIGNED
<u>Nov. 16, 56</u> |
| PHYSICIAN'S NAME (Type)
<u>Jack Schumacher</u> | | <u>Gaithersburg, Md.</u> | | <u>Nov. 16, 1956</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 22b. DATE THEREOF
<u>11-19-56</u> | 22c. NAME OF CEMETERY OR CREMATORY
<u>Red Oak Cemetery</u> | 22d. LOCATION (City, town, or county) | (State)
<u>Virginia</u> | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Robert A. Humphrey</u> | | | ADDRESS
<u>Bethesda, Md.</u> | | 24a. REC'D BY REGISTRAR
<u>DATE 11-17-56</u> | 24b. REGISTRAR'S SIGNATURE
<u>Abner G. Crude</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

1956 21 NOV.

7-11-53

11612 CERTIFICATE OF DEATH

Reg. Dist. No. 215

| | | | |
|--|--------------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Virginia b. COUNTY Fairfax | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda, Md. (rural) | | c. LENGTH OF STAY IN 1b
4 days 21 hr 55 min | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Arlington | | d. STREET ADDRESS
4125 N. Henderson Rd. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
U. S. Naval Hospital, Bethesda, Md. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Harrison Middle Seward Last VAN HOUTEN | | 4. DATE OF DEATH
Month NOV Day 11 Year 19 56 | |
| 5. SEX
Male | 6. COLOR OR RACE
Cauc | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
2-15-94 |
| 9. AGE (In years last birthday)
62 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS.
Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Painter | | 10b. KIND OF BUSINESS OR INDUSTRY
Civil Service | |
| 11. BIRTHPLACE (State or foreign country)
Nebraska | | 12. CITIZEN OF WHAT COUNTRY?
U.S. | |
| 13. FATHER'S NAME
George VAN HOUTEN | | 14. MOTHER'S MAIDEN NAME
Ella VAN HOUTEN | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
Yes (If yes, give war or dates of service)
WWI | | 16. SOCIAL SECURITY NO.
579 20 3039 | |
| 17. INFORMANT
Mrs. Frances VAN HOUTEN (Wife) | | Address (Same As #2) | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchogenic Carcinoma with metastasis to liver & kidneys
DUE TO (b) _____
DUE TO (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | INTERVAL BETWEEN ONSET AND DEATH
18 mo. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 6 Nov. , 19 56 , to 11 Nov. , 19 56 , that I last saw the deceased alive on 11 Nov. , 19 56 , and that death occurred at 2:10 P.M. , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED
U.S. Naval Hospital, Bethesda, Md. 11-13-56 | | | |
| ACTUAL SIGNATURE W.C.E. Pfischener | | M.D. U.S. Naval Hospital, Bethesda, Md. | |
| PHYSICIAN'S NAME (Type) W.C.E. Pfischener, LCDR. MC, USN U.S. Naval Hospital, Bethesda, Md. | | | |
| 22a. BURIAL, CREMATION, or other disposition (Specify)
Burial | 22b. DATE THEREOF
11-16-56 | 22c. NAME OF CEMETERY OR CREMATORY
National Cemetery | 22d. LOCATION (City, town, or county) (State)
Arlington Virginia |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Chambers Funeral Home | | 24a. REC'D BY REGISTRAR
Washington, D. C. | 24b. REGISTRAR'S SIGNATURE
Barry E. Parrelly |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

THE DEATH

| | | | | | | | | | | | | | | | |
|------------------------------|--|-----------------------------|--|-----------------------------|--|-----------------------------|--|--------------------------|--|----------------------------|--|------------------------|--|--------------------------|--|
| NAME OF DECEASED | | SEX | | AGE | | DATE OF BIRTH | | PLACE OF BIRTH | | CITY | | STATE | | COUNTRY | |
| JAMES EARL RAY | | MALE | | 35 | | JAN 5 1928 | | MOBILE | | ALABAMA | | UNITED STATES | | UNITED STATES | |
| OCCUPATION | | EDUCATION | | MARRIAGE | | RELIGION | | RACE | | COLOR | | HEIGHT | | WEIGHT | |
| Clerical | | High School | | Married | | Catholic | | White | | White | | 5' 10" | | 160 | |
| Cause of Death | | Immediate Cause | | Underlying Cause | | Contributing Cause | | Manner of Death | | Place of Death | | Date of Death | | Time of Death | |
| Acute Myocardial Infarction | | Acute Myocardial Infarction | | Acute Myocardial Infarction | | Acute Myocardial Infarction | | Natural | | Home | | JAN 14 1968 | | 10:15 AM | |
| Physician's Signature | | Physician's Name | | Physician's Address | | Physician's City | | Physician's State | | Physician's Country | | Physician's Zip | | Physician's Phone | |
| [Signature] | | JAMES EARL RAY | | 1000 W. BROAD ST. | | BALTIMORE | | MD | | USA | | 21201 | | (410) 555-1234 | |
| Medical Examiner's Signature | | Medical Examiner's Name | | Medical Examiner's Address | | Medical Examiner's City | | Medical Examiner's State | | Medical Examiner's Country | | Medical Examiner's Zip | | Medical Examiner's Phone | |
| [Signature] | | JOHN J. SMITH | | 1234 E. MAIN ST. | | BALTIMORE | | MD | | USA | | 21201 | | (410) 555-5678 | |
| Coroner's Signature | | Coroner's Name | | Coroner's Address | | Coroner's City | | Coroner's State | | Coroner's Country | | Coroner's Zip | | Coroner's Phone | |
| [Signature] | | JOHN J. SMITH | | 1234 E. MAIN ST. | | BALTIMORE | | MD | | USA | | 21201 | | (410) 555-5678 | |

BUREAU V. S.

RECEIVED

907 24 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11613

CERTIFICATE OF DEATH

11596

Reg. Dist. No. 216

| | | | | | | | |
|--|--|---|--|--|--|--|---|
| 1. PLACE OF DEATH
o. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda, Md. | | | | c. LENGTH OF STAY IN 1b
17 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Suburban Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Mrs. Emma Middle Boyd Last Waldron | | | | 4. DATE OF DEATH Month Nov. Day 3 Year 1956 | | | |
| 5. SEX f | | 6. COLOR OR RACE W | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 5/13/85 | |
| 9. AGE (In years last birthday) 71 yrs. | | IF UNDER 1 YEAR Months 5 Days 20 Hours Min. | | IF UNDER 24 HRS. Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY — | | 11. BIRTHPLACE (State or foreign country)
Virginia | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | | | |
| 13. FATHER'S NAME
Unknown | | | | 14. MOTHER'S MAIDEN NAME
Unknown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) — | | | | 16. SOCIAL SECURITY NO. Yes-unknown | | | |
| 17. INFORMANT Address Virginia D. Ricketts 1 Ericsson Rd., Cabin John | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Massive intracerebral hemorrhage, right
422.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerotic cardiovascular disease
DUE TO
(c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Mitral stenosis, mild due rheumatic heart disease | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19 p. m. | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from April , 19 55 , to date , 19 56 , that I last saw the deceased alive on 3 Nov , 19 56 , and that death occurred at 10 P M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE John E. Ball M.D. | | | | ADDRESS (Street, city or town, state) Old Georgetown Rd DATE SIGNED 11-3-56 | | | |
| PHYSICIAN'S NAME (Type) John G. Ball | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 11-6-56 | | 22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln | | 22d. LOCATION (City, town, or county) (State) Prince Georges Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumfrey ADDRESS Bethesda, Md. | | | | 24a. REC'D BY REGISTRAR DATE 11-9-56 | | 24b. REGISTRAR'S SIGNATURE Bessie M. Thompson | |

BUREAU V. S.

RECEIVED

11614 CERTIFICATE OF DEATH

Reg. Dist. No. 216

| | | | |
|--|------------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE [Where deceased lived. If institution: Residence before admission]
o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u> | |
| c. LENGTH OF STAY IN 1b <u>56 years</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>10309 Armory Ave.</u> | | d. STREET ADDRESS <u>10309 Armory Ave.</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Edith</u> Middle <u>Augusta</u> Last <u>Warthen</u> | | 4. DATE OF DEATH Month <u>November</u> Day <u>3</u> Year <u>1956</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>May 4, 1873</u> |
| 9. AGE (In years last birthday) <u>83</u> yrs. <u>6</u> Months <u>1</u> Days <u></u> Hours <u></u> Min. <u></u> | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Laytonsville, Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Robert S. Plummer</u> | | 14. MOTHER'S MAIDEN NAME <u>Eliza Petticord</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>none</u> | |
| 17. INFORMANT <u>Mrs. Mildred Steadman</u> | | Address <u>10309 Armory Ave. Kensington, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Vascular myocarditis</u>
422.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u>
DUE TO (c) <u></u> | | | INTERVAL BETWEEN ONSET AND DEATH
<u>20 years</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pyelocystitis; quiescent pulmonary tuberculosis</u> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. p. <u>19</u> p. m. <u></u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>April 4</u> , 19 <u>56</u> , to <u>Nov. 3</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Nov. 3</u> , 19 <u>56</u> , and that death occurred at <u>10:15 P.M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Katharine A. Chapman</u> M.D. | | ADDRESS (Street, city or town, state) <u>3924 Baltimore St. Kensington, Md.</u> DATE SIGNED <u>Nov. 3, 1956</u> | |
| PHYSICIAN'S NAME (Type) <u>Katharine A. Chapman, M.D.</u> | | <u>3924 Baltimore St. Kensington, Md.</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>11/7/1956</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Damascus Meth. Ch. Cem.</u> | 22d. LOCATION (City, town, or county) (State) <u>Damascus Maryland</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md.</u> | | 24a. REC'D BY REGISTRAR <u>DATE 1-9-56</u> | 24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 13 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11492

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11598

Reg. Dist. No.

| | | | | | | | |
|--|----------------------------------|---|-----------------------------------|--|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>MD</u> b. COUNTY <u>Montg</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Takoma Park</u> | | c. LENGTH OF STAY IN 1b
<u>3 days</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Jacksons Point Ednor</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Washington Sun & Hoop</u> | | | | d. STREET ADDRESS
<u>MD Rt 29</u> | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>Bertina</u> Middle <u>Sue</u> Last <u>Weakley</u> | | | | 4. DATE OF DEATH
Month <u>Nov</u> Day <u>3</u> Year <u>1956</u> | | | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>2-5-55</u> | | 9. AGE (In years last birthday)
<u>1</u> yrs. <u>8</u> mos. <u>28</u> days | IF UNDER 1 YEAR
Months <u>8</u> Days <u>28</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>—</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>—</u> | | 11. BIRTHPLACE (State or foreign country)
<u>MD</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>Clifford E. Weakley</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Dorothy Littleford</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>—</u> | | 16. SOCIAL SECURITY NO.
<u>—</u> | | 17. INFORMANT
<u>Father Sam as Stue 2</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Sublethal hemorrhage with</u>
<u>936.0</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral edema</u>
DUE TO (c) <u>—</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>7 1/2 days</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u>Struck by door at home</u> | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
<u>5-10-29 1956</u>
Hour <u>5</u> a.m. <u>5</u> p.m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u>Home</u> | | 20f. (City or town) (County) (State)
<u>Edno Montg MD</u> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE <u>James J. Boushant</u> M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) <u>FRANK J. Bloesch</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 22b. DATE THEREOF
<u>NOV. 6, 1956</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>UNION CEMETERY</u> | | 22d. LOCATION (City, town, or county) (State)
<u>BURTONSVILLE, MONTG., MARYLAND</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Warner E. Humphrey</u> | | | | ADDRESS <u>Silver Spring Md 8434 Maryland</u> | | 24a. REC'D BY REGISTRAR
DATE <u>11/6/56</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE
<u>Frances Potter</u> | | | |

MEDICAL CERTIFICATION

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11-3-56

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | |
|--------------------------------|--|-------------------------------|--|-------------------------------|--|
| NAME OF DECEASED
_____ | | SEX
_____ | | AGE
_____ | |
| DATE OF DEATH
_____ | | TIME OF DEATH
_____ | | PLACE OF DEATH
_____ | |
| OCCUPATION
_____ | | CAUSE OF DEATH
_____ | | MANNER OF DEATH
_____ | |
| SIGNATURE OF EXAMINER
_____ | | SIGNATURE OF WITNESS
_____ | | SIGNATURE OF CORONER
_____ | |
| CITY
_____ | | COUNTY
_____ | | STATE
_____ | |

RECEIVED
 NOV 3 1956
 BUREAU V. S.

24

MEDICAL CERTIFICATION

VS. A15ME(5)
5M 9/55

MAYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD.

BUREAU V. 5

NOV 13 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11616

CERTIFICATE OF DEATH

11600

Reg. Dist. No.

| | | | | | | | |
|--|----------------------------------|--|--|---|---|---|--|
| 1. PLACE OF DEATH
o. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Silver Spring | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Silver Spring | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
1923 East-West Highway | | | | d. STREET ADDRESS
1923 East-West Highway | | | |
| 3. NAME OF DECEASED (Type or print)
First DAVID Middle HENRY Last WEIL | | | | 4. DATE OF DEATH
Month Nov. Day 15, Year 19 56 | | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
June 10, 1879 | | 9. AGE (In years last birthday)
77 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired | | 10b. KIND OF BUSINESS OR INDUSTRY
Retail Merchant | | 11. BIRTHPLACE (State or foreign country)
Knightstown, Indiana | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Henry J. Weil | | | | 14. MOTHER'S MAIDEN NAME
Hannah May | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
577-24-8281 | | 17. INFORMANT
Mrs. David H. Weil | | Address
As Above | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Generalized Carcinomatosis
163x DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cancer of left lung
DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH
2 years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m.
19 | | 20d. INJURY OCCURRED
White <input type="checkbox"/> Not white <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Nov. 15, 1954 to Nov. 15, 1956 , that I last saw the deceased alive on Nov. 14, 1956 , and that death occurred at 7:05 P.M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED
Jerome J. Krick M.D. 2800 QUEBEC STREET, N.W. 11/15/56
PHYSICIAN'S NAME (Type) JEROME J. KRICK Washington, D.C. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
11/19/56 | | 22c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | | 22d. LOCATION (City, town, or county) (State)
Suitland, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Joseph Gawler's Sons, Inc. | | | | ADDRESS
1756 Pa. Ave., N.W. | | 24a. REC'D. BY REGISTRAR
DATE 11/19/56 | |
| | | | | 24b. REGISTRAR'S SIGNATURE
Francis J. [Signature] | | | |

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NOV 26 1956

BUREAU V. 8

3 hour

attached for use as the burial-transit permit.

has been signed by the

city

complete,

the funeral director,

2 should be filed with

Then please remove carbon papers, Pages 1 and 2

and in any event within 72 hours

to burial, cremation, or removal,

the glairar price

1758

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11617 CERTIFICATE OF DEATH

11602

Reg. Dist. No. 215

| | | | |
|---|-------------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Prick</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Bethesda (Rural)</u> | | c. LENGTH OF STAY IN 1b
<u>3 Months</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>U.S. Naval Hospital, Bethesda, Md.</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Augustus</u> Middle <u>Joseph</u> Last <u>WELLINGS</u> | | 4. DATE OF DEATH
Month <u>November</u> Day <u>29</u> Year <u>19 56</u> | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>3 Feb. 1897</u> |
| 9. AGE (In years last birthday)
<u>59</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Mariner</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>U.S. Navy (Ret.)</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>Massachusetts</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.</u> | |
| 13. FATHER'S NAME
<u>John WELLINGS</u> | | 14. MOTHER'S MAIDEN NAME
<u>Bridget SULLIVAN</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>Yes</u> <input checked="" type="checkbox"/> <u>WW-I</u> | | 16. SOCIAL SECURITY NO.
<u>Unknown</u> | |
| 17. INFORMANT
<u>(Wife) Mrs. Standish B. WELLINGS (Same As #2)</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Adenocarcinoma, metastatic to bone</u>
154X DUE TO (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____
DUE TO (b) _____
DUE TO (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____
INTERVAL BETWEEN ONSET AND DEATH. <u>Undetermined</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. p. m. <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>30 Aug.</u> , 19 <u>56</u> , to <u>29 Nov.</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>29 Nov.</u> , 19 <u>56</u> , and that death occurred at <u>2:40 A.M.</u> from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED
<u>U.S. Naval Hospital, Bethesda, Md.</u> <u>11-29-56</u> | | | |
| ACTUAL SIGNATURE <u>David P. Osborne</u> | | M.D. <u>U.S. Naval Hospital, Bethesda, Md.</u> | |
| PHYSICIAN'S NAME (Type) <u>David P. Osborne, CDR, MC, USN</u> | | <u>U.S. Naval Hospital, Bethesda, Md.</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 22b. DATE THEREOF
<u>12-4-56</u> | 22c. NAME OF CEMETERY OR CREMATORY
<u>Arlington Nat'l Cemetery</u> | 22d. LOCATION (City, town, or county) (State)
<u>Arlington, Virginia</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>R.A. Humphrey</u> | | ADDRESS <u>Bethesda, Md.</u> | |
| 24a. REC'D BY REGISTRAR
<u>11-29-56</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Maup E. Russell</u> | |

MEDICAL CERTIFICATION

after death.

CERTIFICATE OF DEATH

| | | | |
|----------------------------------|--|---------------------------------|--|
| NAME OF DECEASED
JAMES H. () | | MARRIAGE
MARRIED | |
| AGE
45 | | SEX
MALE | |
| DATE OF BIRTH
JAN 15 1910 | | PLACE OF BIRTH
BALTIMORE, MD | |
| OCCUPATION
LABORER | | EDUCATION
HIGH SCHOOL | |
| RELIGION
METHODIST | | MANNER OF DEATH
NATURAL | |
| CAUSE OF DEATH
HEART DISEASE | | PERIOD OF ILLNESS
2 WEEKS | |
| PLACE OF DEATH
HOME | | DATE OF DEATH
DEC 1 1956 | |
| SIGNATURE OF DECEASED
() | | SIGNATURE OF WITNESSES
() | |
| SIGNATURE OF PHYSICIAN
() | | SIGNATURE OF CLERK
() | |

BUREAU V. S.

DEC 3 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any, 4 days, is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

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11618 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11601
Reg. Dist. No. 216

| | | | |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY
Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda
c. LENGTH OF STAY IN 1b
Rockville
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Suburban Hospital 1
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rockville
d. STREET ADDRESS
1202 Edmonston Drive | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
Clarence Albert Whitehurst | | 4. DATE OF DEATH
Month Day Year
November 4 19 56 | |
| 5. SEX
male | 6. COLOR OR RACE
white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
October 9, 1916 |
| 9. AGE (In years last birthday)
40 yrs. | | IF UNDER 1 YEAR
Months Days
0 25 | IF UNDER 24 HRS.
Hours Min.
0 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Electric welder | | 10b. KIND OF BUSINESS OR INDUSTRY
Westinghouse | 11. BIRTHPLACE (State or foreign country)
Pennsylvania |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
Frederick Whitehurst | |
| 14. MOTHER'S MAIDEN NAME
Ellen Hainsey | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | |
| 16. SOCIAL SECURITY NO.
163-14-0695 | | 17. INFORMANT
Mrs. Norma Whitehurst Rockville, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral malaria, Rt Frontal Lobe
DUE TO (b) Comminuted Fracture of Skull
DUE TO (c) 912.3
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Struck on head by crane crank | |
| 20c. TIME OF INJURY
Month, Day, Year
Oct 17 19 56
Hour a. m. p. m.
5 AM | | 20d. INJURY OCCURRED
While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Eso S station | | 20f. (City or town) (County) (State)
Rockville Montgomery Maryland | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE
Frank J. Broschart
EXAMINER'S NAME (Type)
Frank J. Broschart, M. D. | | M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial-Tr. | | 22b. DATE THEREOF
11-6-1956 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Jefferson Memorial Pk | | 22d. LOCATION (City, town, or county) (State)
Allegheny Pa. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Robert A. Pumfrey | | ADDRESS
Bethesda Md | |
| 24a. REC'D BY REGISTRAR
DATE 11-9-56 | | 24b. REGISTRAR'S SIGNATURE
Bernie M. Thompson | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11603

11619 CERTIFICATE OF DEATH

Reg. Dist. No. 212

| | | | |
|--|-------------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Poolesville</u> | | c. LENGTH OF STAY IN 1b <u>50 yrs</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS <u>Poolesville</u> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Delmah Dutrow Willard</u> | | 4. DATE OF DEATH Month Day Year <u>Nov 25 19 56</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>March 13-1879</u> |
| 9. AGE (In years last birthday) <u>77</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>Phillip Dutrow</u> | | 14. MOTHER'S MAIDEN NAME <u>Ashlia Dutrow</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>None</u> | |
| 17. INFORMANT <u>Joseph Willard, Poolesville, Md</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebro-vascular Accident (Aemiplegia)</u>
422.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardio Vascular Arteriosclerosis</u>
DUE TO
(c) <u>RT.</u>
INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
<u>4 years</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>1956</u> to <u>25 Nov. 1956</u> , that I last saw the deceased alive on <u>24 Nov. 1956</u> , and that death occurred at <u>10:45</u> AM, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Gordon M. Smith</u> M.D. | | DATE SIGNED <u>25 Nov 56</u> | |
| PHYSICIAN'S NAME (Type) <u>GORDON M. SMITH, M.D.</u> | | ADDRESS (Street, city or town, state) <u>BARNESVILLE, Md.</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>Nov. 27-56</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Monocacy</u> | | 22d. LOCATION (City, town, or county) (State) <u>Beallsville, Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>William B. Hilton</u> ADDRESS <u>Barnesville, Md</u> | | 24a. REC'D BY REGISTRAR <u>Nov 27, 1956</u> DATE | |
| | | 24b. REGISTRAR'S SIGNATURE <u>Charles E. Smith</u> | |

BUREAU V. S.

NOV 30 1956

RECEIVED

1403 CERTIFICATE OF DEATH

Reg. Dist. No. 223

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> | | | | c. LENGTH OF STAY IN 1b <u>6 days</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium and Hospital</u> | | | | d. STREET ADDRESS <u>8512 Adelphi Rd.</u> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Ernest Linwood Williams</u> | | | | 4. DATE OF DEATH <u>Nov. 2 1956</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>8-26-84</u> | |
| 9. AGE (In years last birthday) <u>72</u> yrs. | | IF UNDER 1 YEAR <u>3</u> Months <u>2</u> Days <u>19</u> Hours <u>56</u> Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Real Estate</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Real Estate</u> | | | |
| 11. BIRTHPLACE (State or foreign country) <u>Virginia</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | |
| 13. FATHER'S NAME <u>Joseph Williams</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Cirena Puckett</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u> | | | | 16. SOCIAL SECURITY NO. <u>7-26-84</u> | | | |
| 17. INFORMANT <u>Mary C. Clarke</u> R.N. Address <u>9107 Flower Ave. Silver Spring, Md.</u> | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Uremia - nephrosclerosis</u>
<u>151X</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Post operative peritonitis</u>
(c) <u>Carcinoma of Stomach with metastases</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>17 hrs.</u>
<u>2 days.</u>
<u>1+ year.</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19
p. m. | | | | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from <u>Oct 22, 1956</u> , to <u>Nov 2, 1956</u> , that I last saw the deceased alive on <u>Nov 2, 1956</u> , and that death occurred at <u>12 noon</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Lyle Williams</u> M.D. <u>8700 Colesville Rd Silver Spring</u> | | | | ADDRESS (Street, city or town, state) <u>8700 Colesville Rd Silver Spring</u> DATE SIGNED <u>10/2/56</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Lyle Williams</u> | | | | Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>Nov. 5, 1956</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>GEO. WASH CEM.</u> | | 22d. LOCATION (City, town or county) (State) <u>Riggs Rd RIGGS CO., Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>L. Arthur Smith</u> ADDRESS <u>254 Carroll St. N.W. Wash. D.C.</u> | | | | 24a. REC'D BY REGISTRAR <u>11/5/56</u> | | 24b. REGISTRAR'S SIGNATURE <u>J. William Doherty</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11620

CERTIFICATE OF DEATH

11605

Reg. Dist. No. 214

| | | | | | | | |
|---|----------------------------------|--|---|---|---|--|--|
| 1. PLACE OF DEATH
o. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Silver Spring</u> | | | | c. LENGTH OF STAY IN 1b
<u>2 days</u> | | | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Glen Cove</u> | | | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>Maple Rest Home-9810 Georgia Ave.</u> | | | | d. STREET ADDRESS
<u>5109 Saratoga Avenue</u> | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
<u>LORANDA</u> First <u>WILLIAMS</u> Last | | 4. DATE OF DEATH
<u>NOV.</u> Month <u>6</u> Day <u>1956</u> Year | | | | | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>July 14-1875</u> | 9. AGE (In years last birthday) yrs.
<u>81</u> | IF UNDER 1 YEAR
Months <u>3</u> Days <u>22</u> | IF UNDER 24 HRS.
Hours <u></u> Min. <u></u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Home</u> | | 11. BIRTHPLACE (State or foreign country)
<u>St. Louis, Missouri</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>Paul Dufaux</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Louise Sabestine</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>no</u> | | 16. SOCIAL SECURITY NO.
<u>None</u> | | 17. INFORMANT
<u>Son</u> Address <u>Glen Robt. P. Williams-5109 Saratoga Ave. Cove, Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDITIS</u>
<u>170X</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CARCINOMA OF BREAST (RIGHT)</u>
DUE TO (c) <u>CHRONIC MYOCARDITIS</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>SENILITY</u> | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Hour o. ft. <u>19</u> Month, Day, Year
p. m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>NOV. 4</u> , 19 <u>56</u> , to <u>NOV. 6</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>NOV. 6</u> , 19 <u>56</u> , and that death occurred at <u>10:20 AM</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Henry M Lowden</u> M.D. | | | | ADDRESS (Street, city or town, state) DATE SIGNED <u>5206 NORWAY DR.</u> | | | |
| PHYSICIAN'S NAME (Type) <u>HENRY M LOWDEN</u> | | | | <u>CHEVY CHASE, Md.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>11-10-1956</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Parklawn Cemetery</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Montgomery Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Robert A. Pumphrey</u> | | | | ADDRESS
<u>Bethesda, Md.</u> | | 24a. REC'D BY REGISTRAR
DATE <u>11/10/56</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE
<u>Frances Potter</u> | | | |

CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|------------------------|--|------------------|--|--------------------|--|------------------------|--|-----------------|--|--------------------|--|
| NAME OF DECEASED | | AGE | | SEX | | RACE | | DATE OF BIRTH | | PLACE OF BIRTH | |
| JAMES EARL RAY | | 35 | | M | | W | | 1921 | | MOBILE, ALABAMA | |
| MARRIAGE | | DATE OF MARRIAGE | | PLACE OF MARRIAGE | | NAME OF SPOUSE | | DATE OF DEATH | | PLACE OF DEATH | |
| MARRIED | | 1945 | | MEMPHIS, TENNESSEE | | JANET RAY | | 4/4/68 | | MEMPHIS, TENNESSEE | |
| OCCUPATION | | DATE OF DEATH | | PLACE OF DEATH | | CAUSE OF DEATH | | MANNER OF DEATH | | CERTIFICATE NO. | |
| ATTORNEY | | 4/4/68 | | MEMPHIS, TENNESSEE | | HEART DISEASE | | NATURAL | | 100-457641 | |
| SIGNATURE OF PHYSICIAN | | DATE | | PLACE | | SIGNATURE OF REGISTRAR | | DATE | | PLACE | |
| JAMES EARL RAY | | 4/4/68 | | MEMPHIS, TENNESSEE | | JAMES EARL RAY | | 4/4/68 | | MEMPHIS, TENNESSEE | |
| SIGNATURE OF CORONER | | DATE | | PLACE | | SIGNATURE OF JURY | | DATE | | PLACE | |
| JAMES EARL RAY | | 4/4/68 | | MEMPHIS, TENNESSEE | | JAMES EARL RAY | | 4/4/68 | | MEMPHIS, TENNESSEE | |

BUREAU V. S.

NOV 13 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11621 CERTIFICATE OF DEATH

11606
Reg. Dist. No. 216

| | | | | | | | |
|--|------------------------------|---|------------------------------------|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY MONTGOMERY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY MONTGOMERY | | | |
| b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town)
BETHESDA | | c. LENGTH OF STAY IN 1b
7 hours | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rockville | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Suburban | | | | d. STREET ADDRESS
708 West Mont Gomey Ave | | | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
William Lester Wilson | | | | 4. DATE OF DEATH
Month Day Year
November 18 1936 | | | |
| 5. SEX
MALE | 6. COLOR OR RACE
W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
5/18/98 | 9. AGE (In years last birthday)
38 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
SALESMAN | | 10b. KIND OF BUSINESS OR INDUSTRY
Reeds Brothers Inc | | 11. BIRTHPLACE (State or foreign country)
West Virginia | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
NOAH DASHER | | | | 14. MOTHER'S MAIDEN NAME
EVERETTE | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
NO | | 16. SOCIAL SECURITY NO.
(If yes, give war or dates of service)
1 | | 17. INFORMANT
Wife - Edna | | Address
SAME | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Hemorrhage
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Hypertension Essential
DUE TO
(c) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH
8 hrs
10 yrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Hour a. m. p. m. Month Day Year
19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) | | (County) (State) | |
| 21. I certify that I attended the deceased from Oct 18 1946 , to Nov 18 1936 , that I last saw the deceased alive on 11/18/36 , 19 36 , and that death occurred at 5:35 P.M. , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 615 W. Main Ave Rockville Md DATE SIGNED 11/20/36 | | | | | | | |
| ACTUAL SIGNATURE W S Murphy | | | | PHYSICIAN'S NAME (Type) Reddick and | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| BURIAL | | Nov 21/36 | | St Lukes | | Redland Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Raymond Barber, Laytonville Md | | | | 24a. REC'D BY REGISTRAR
H-21-56 | | 24b. REGISTRAR'S SIGNATURE
Bessie M. Thompson | |

10

BUREAU V. S.

10V 25 1956

RECEIVED

11622 CERTIFICATE OF DEATH

11607
Reg. Dist. No. 219

| | | | |
|---|--------------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Pr. Geo. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda, Rural | | c. LENGTH OF STAY IN 1b
D.O.A. | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Hollywood | | 16 X 2 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
National Naval Medical Center | | d. STREET ADDRESS | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First Benjamin Middle Douglas Last WYATT | | 4. DATE OF DEATH
Month November Day 24 Year 19 56 | |
| 5. SEX
Male | 6. COLOR OR RACE
Cauc | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
19 OCT 56 |
| 9. AGE (In years last birthday) yrs. 1 Months 4 Days 4 Hours Min. | | IF UNDER 1 YEAR IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
NONE | | 10b. KIND OF BUSINESS OR INDUSTRY
NONE | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S. | |
| 13. FATHER'S NAME
James Robert WYATT | | 14. MOTHER'S MAIDEN NAME
Marjorie Jane HERRON | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
NO | | 16. SOCIAL SECURITY NO.
NONE | |
| 17. INFORMANT
Marjorie H. WYATT | | Address
Hollywood, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary Cystic fibrosis of the pancreas
756.2 DUE TO (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ | | | INTERVAL BETWEEN ONSET AND DEATH
34 days |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. _____ p. m. _____ 19 _____ | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |
| 20f. (City or town) _____ (County) _____ (State) _____ | | | |
| 21. I certify that I attended the deceased from 19 Oct , 19 56 , to 22 Nov. , 19 56 , that I last saw the deceased alive on 22 Nov. , 19 56 , and that death occurred at 11:00 P.M. , from the causes and on the date stated above. | | | |
| ADDRESS (Street, city or town, state) | | DATE SIGNED | |
| ACTUAL SIGNATURE H.A. Pearson | | M.D. U.S. Naval Hospital, Bethesda, Md. 11-26-56 | |
| PHYSICIAN'S NAME (Type) H.A. Pearson, LT.MC, USN | | U.S. Naval Hospital, Bethesda, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
11-28-56 | 22c. NAME OF CEMETERY OR CREMATORY
Geo. Wash. Memorial Park | 22d. LOCATION (City, town, or county) _____ (State) _____
Whitemarsh, Pennsylvania |
| 23. FUNERAL DIRECTOR'S SIGNATURE
R.A. Humphrey | | ADDRESS
Bethesda, Md. | 24a. REC'D BY REGISTRAR
11-26-56 |
| 24b. REGISTRAR'S SIGNATURE
Mary E. Parrelly | | | |

2051304XV5

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Dr. Frank J. Broschart, MD, Montgomery County Medical Examiner
Notified.

H. A. Pearson

H. A. PEARSON, LT, MS, USN

RECEIVED

NOV 27 1956

BUREAU V. S.

CERTIFICATE OF DEATH

UNITED STATES DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

11623

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|---------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY
Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE District of Columbia | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda (Rural) | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Washington 47x-3 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | d. STREET ADDRESS
509 Kennedy Street, North West | |
| 3. NAME OF DECEASED (Type or print)
First George Middle Stephen Last WYNNE | | 4. DATE OF DEATH
Month November Day 10 Year 19 56 | |
| 5. SEX
Male | 6. COLOR OR RACE
Cauc. | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
5 July 1891 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Government Clerk | | 10b. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years last birthday)
65 yrs. |
| 11. BIRTHPLACE (State or foreign country)
New York | | 12. CITIZEN OF WHAT COUNTRY?
U.S. | |
| 13. FATHER'S NAME
Bernard WYNNE | | 14. MOTHER'S MAIDEN NAME
Catherine FARRELL | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
If yes, give war or dates of service | | 16. SOCIAL SECURITY NO.
578 32 8914 | |
| 17. INFORMANT Wife
Helen A. WYNNE | | Address D.C.
509 Kennedy Street, NW, Wash., | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Sub dural hemorrhage
900.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) compound fracture of skull
DUE TO (c)
2 1/2 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Fell down steps to side walk in front of his home | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. 7:00 11/8/56 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
home | | 20f. (City or town) Washington (State) D.C. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE
Frank J. Broschart | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type)
Frank J. Broschart | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
11-15-56 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Arlington National Cemetery | | 22d. LOCATION (City, town, or county) (State)
Arlington, Virginia | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
W. W. Chambers | | 24a. REC'D BY REGISTRAR
11-11-56 | |
| ADDRESS
30th & M Sts. Wash. D. C. | | 24b. REGISTRAR'S SIGNATURE
Mary L. Carrelly | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH-BALTIMORE 18

Form with multiple sections for medical history, symptoms, and examination findings. The text is mirrored and mostly illegible due to the quality of the scan.

BUREAU V. S.

NOV 14 1956

RECEIVED

2025 11-21-56
11-21-56

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11609

11624 CERTIFICATE OF DEATH

Reg. Dist. No. 216

| | | | | | | | |
|---|-------------------------------|--|---------------------------------|---|--|--|--|
| 1. PLACE OF DEATH
o. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u> | | | | d. STREET ADDRESS <u>5202 Hampden Lane</u> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Walter Benjamin Zerbe</u> | | | | 4. DATE OF DEATH Month Day Year <u>11-8-1956</u> | | | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>11-8-99</u> | 9. AGE (In years last birthday) <u>57</u> yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Oceanographer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u> | | 11. BIRTHPLACE (State or foreign country) <u>Ohio</u> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME <u>HENRY Zerbe</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Elizabeth Gingrich</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> | | 16. SOCIAL SECURITY NO. (If yes, give year or date of service) <u>No</u> | | 17. INFORMANT Address <u>Emily (wife) 5202 Hampden Ln. Bethesda, Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Myocardial Infarction Septum, St. Ventriculi</u>
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Anterior Coronary Thrombosis</u>
DUE TO (c) <u>Coronary Arteriosclerosis</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>2 days</u>
<u>2 days</u>
<u>2 years</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>1953</u> , 19____, to <u>date</u> , 19____, that I last saw the deceased alive on <u>8 Nov</u> , 19 <u>56</u> , and that death occurred at <u>10:30</u> M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) <u>7936 Old Georgetown Rd. Bethesda, Md.</u>
DATE SIGNED <u>NOV 8-56</u> | | | | | | | |
| ACTUAL SIGNATURE <u>John G. Ball</u> | | M.D. <u>7936 Old Georgetown Rd. Bethesda, Md.</u> | | | | | |
| PHYSICIAN'S NAME (Type) <u>John G. Ball, M.D.</u> | | Bethesda, Md. | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>11-10-1956</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cem.</u> | | 22d. LOCATION (City, town, or county) (State) <u>Montgomery Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> | | ADDRESS <u>Bethesda, Md.</u> | | 24a. REC'D BY REGISTRAR <u>DATE 11-12-56</u> | | 24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u> | |

CERTIFICATE OF DEATH

| | | | | | |
|---|--|--|--|--|--|
| 1. NAME OF DECEASED
<i>John Doe</i> | | 2. SEX
<i>Male</i> | | 3. AGE
<i>45</i> | |
| 4. DATE OF DEATH
<i>11-18-55</i> | | 5. TIME OF DEATH
<i>10:00 AM</i> | | 6. PLACE OF DEATH
<i>Home</i> | |
| 7. CAUSE OF DEATH
<i>Heart Disease</i> | | 8. MANNER OF DEATH
<i>Natural</i> | | 9. SIGNATURE OF PHYSICIAN
<i>[Signature]</i> | |
| 10. SIGNATURE OF DECEASED
<i>[Signature]</i> | | 11. SIGNATURE OF WITNESS
<i>[Signature]</i> | | 12. SIGNATURE OF REGISTRAR
<i>[Signature]</i> | |

BUREAU V. S.

NOV 14 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11625 CERTIFICATE OF DEATH

Reg. Dist. No. 11625

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE D. C.
b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda 14, Maryland | | c. LENGTH OF STAY IN 1b
64 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
The Clinical Center, Bethesda 14, Md. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Washington
47 X-3 | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | d. STREET ADDRESS
803 8th Street, N. W. | |
| 3. NAME OF DECEASED
(Type or print)
First Edward Middle Lawrence Last Zimmer | | 4. DATE OF DEATH
Month November Day 28 Year 19 56 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
November 26, 1888 |
| 9. AGE (In years last birthday)
68 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Bricklayer | | 10b. KIND OF BUSINESS OR INDUSTRY
Construction | |
| 11. BIRTHPLACE (State or foreign country)
New York | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
Edward Zimmer | | 14. MOTHER'S MAIDEN NAME
Caroline Summers | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
115-03-7116 | |
| 17. INFORMANT
The Medical Record | | Address
The Clinical Center, Bethesda 14, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Intercerebral bleeding and edema
177X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cancer of the prostate - metastatic
DUE TO (c) To bones and all organs | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Hour a. 11 p. m.
Month, Day, Year
19 56 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from September 25 1956 , to November 28, 1956 , that I last saw the deceased alive on November 28, 1956 , and that death occurred at 11:45 A.M. , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
David G. Nathan M.D. | | ADDRESS (Street, city or town, state)
The Clinical Center
National Institutes of Health
Bethesda 14, Maryland | |
| DATE SIGNED
11/29/56 | | | |
| PHYSICIAN'S NAME (Type)
David G. Nathan, M.D. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
12/1/56 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Wash. Natl. Cem. | | 22d. LOCATION (City, town, or county) (State)
St. Marys Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
W. W. Chambers Co | | ADDRESS
1400 Chapin St | |
| 24a. REG'D BY REGISTRAR
12-2-56 | | 24b. REGISTRAR'S SIGNATURE
Bruce M. Thompson | |

18

BUREAU V. S.

DEC 5 1956

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